



Massachusetts Health Care Cost Trends Final Report

Appendices C.5a – C.5f: Transcripts for March 16, March 18, and March 19, 2010

April 2010



Deval L. Patrick, Governor
Commonwealth of Massachusetts
Timothy P. Murray
Lieutenant Governor

JudyAnn Bigby, Secretary
Executive Office of Health and Human Services
David Morales, Commissioner
Division of Health Care Finance and Policy

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Massachusetts Health Care Cost Trends Final Report

Appendix C.5a

Health Care Cost Trends Public Hearings

Transcript for Morning Session Tuesday, March 16, 2010

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Volume: Day 1 a.m.
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COMMONWEALTH OF MASSACHUSETTS

Executive Office of Health and Human
Services
Division of Health Care Finance and Policy

PUBLIC HEARING RE:

HEALTH CARE PROVIDER AND PAYER COSTS TRENDS

BEFORE: David Morales, Commissioner

Held at:

University of Massachusetts Boston
Joseph P. Healey Library
100 Morrissey Boulevard
Boston, Massachusetts 02125

Tuesday, March 16, 2010
9:12 a.m.

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P R O C E E D I N G S

COMMISSIONER DAVID MORALES:

Good morning and welcome.

FROM THE AUDIENCE: Good morning.

COMMISSIONER DAVID MORALES:

Thank you, good morning.

I am joined today by three key partners here; Tom O'Brien, Assistant Attorney General; Commissioner Murphy and soon Commissioner John Auerbach for the Department of Public Health.

Again I want to thank you all for coming. My name is David Morales, Commissioner of Health Care Finance and Policy.

I welcome you to the opening day of the Division's public hearings on Health Care Cost Trends.

Before we get started though, I want to take sometime to provide an overview of our goals for the hearings and to explain our general format today.

In 2006 when Massachusetts passed

1 its landmark Health Reform Law it set a
2 model for the nation of designing a path to
3 achieve near universal health insurance
4 coverage.

5 While the effort to expand coverage
6 has proven successful with over 97 percent
7 of the state's residents now insured, the
8 rapid growth of health care costs both
9 locally and across the nation continues to
10 cause significant challenges.

11 Individuals, families, communities
12 and employers are still struggling under the
13 weight of higher health care costs which cut
14 into wage growth, stymy job creation and
15 impact spending on other sectors of the
16 economy at precisely the time we need to
17 rebuild our economy.

18 In fact, the cost of health
19 insurance has grown by approximately 7
20 and-a-half percent each year on average over
21 the last decade while gross domestic product
22 has only increased about 3 and-a-half
23 percent per year during that same period.

24 In the same sense that there was a

1 shared responsibility for expansion in
2 coverage in Massachusetts we must now focus
3 our collective attention to mitigating
4 health care costs and maximizing quality and
5 efficiency in our health care system.

6 There is no easy answer or solution
7 to this challenge.

8 These hearings represent a critical
9 juncture for the Massachusetts health care
10 system and for the Commonwealth in general.

11 In 2008 the legislature passed a
12 law led by Senate President Murray that
13 directed the Division to issue reports on
14 health care costs and to then hold public
15 hearings with key stakeholders on the health
16 care system to help determine the best
17 course forward with action-oriented
18 solutions.

19 These hearings are the culmination
20 of over a year's work researching health
21 care cost growth in the Commonwealth by the
22 Division of Health Care Finance and Policy,
23 the Office of the Attorney General, the
24 Division of Insurance and many others across

1 government and the marketplace.

2 We are committed to developing a
3 more rationale and effective approach to
4 insuring our health care system delivers
5 value, mitigates health care cost and
6 provides quality care.

7 This week's hearings bring together
8 key health care stakeholders -- providers,
9 insurers, employers and consumers and
10 experts.

11 In order to surface the factors
12 driving health care costs and to identify
13 short-term and long-term solutions that will
14 mitigate growth in health care spending in
15 Massachusetts, it is my intention and the
16 intention of my partners from the Division
17 of Insurance, Department of Public Health,
18 the Office of the Attorney General, to
19 surface different and even conflicting
20 perspectives on what is driving the rapid
21 rise of health care cost in Massachusetts
22 and what can be done about it through public
23 policy and changes in industry practices.

24 Ultimately this public dialogue

1 will better situate Massachusetts to
2 contribute its unique experience to the
3 national discussions on access, health care
4 cost containment, quality improvement and
5 offer valuable insight to a final report
6 that the Division will issue to the
7 legislature on strategies for mitigating
8 health care costs and payment reforms.

9 In terms of format, the hearings
10 today will generally be presented in
11 thematic moderated panels with each witness
12 given the opportunity to make brief
13 openings remarks, answer questions and
14 briefly respond to other comments.

15 The Division has identified a
16 representative sample of health care
17 providers and payers to serve as witnesses
18 today.

19 The panelists will be sworn in and
20 will, therefore, provide their testimony
21 under oath.

22 We, in fact, today will not have
23 anyone submit testimony under oath but we
24 will commence Thursday and Friday.

1 While the Moderator will ask the
2 majority of questions, the four of us at the
3 head panel will intervene at any point.

4 In addition, I encourage all of you
5 to engage in the discussion. There are
6 index cards available at the registration
7 table. Please make sure you write any
8 questions you may have for the panelists and
9 give them to members of my team who are here
10 today. Again, index cards are at the front
11 of the registration table when you first
12 come out of the elevator but I strongly
13 encourage you to engage.

14 At the end of each panel the
15 Moderator will then select some of these
16 questions and ask them of the panelists.

17 Before we begin, I also want to
18 quickly review the agenda. We will start
19 today with brief comments from several key
20 state officials.

21 Following their thoughts, we will
22 hear from three of the experts who conducted
23 the research and analysis for the Division's
24 preliminary reports on health care costs

1 released in February -- Cindy Parks Thomas
2 of Brandeis University's Heller School;
3 Dianna Welch of Oliver Wyman Actuarial
4 Consulting and Deborah Chollet of
5 Mathematica Policy Research.

6 Their presentations will be
7 moderated by Professor Stanley Wallack of
8 Brandeis University's Heller School.

9 Later when we hear from the
10 Division of Insurance regarding their
11 hearings, an analysis and expert witness
12 economist, Len Nichols, on "What is the Cost
13 of Doing Nothing?"

14 There will be a short 30-minute
15 break for lunch. The cafeteria is on the
16 first floor. And we will promptly again at
17 1:15 with the Attorney General, Martha
18 Coakley and she will be followed by two
19 panel presentations with employer and
20 consumer representatives respectively.

21 Hopefully, if we can stay on
22 schedule, and I do have a gavel, we should
23 conclude today at 5:00.

24 I am going to now ask the panelists

1 to join us, if you don't mind, before we go
2 into the formal agenda.

3 Cindy, and the others, if you don't
4 mind just coming up to the table.

5 (Panelist seated at the table.)

6 COMMISSIONER DAVID MORALES: At
7 the time I would like for -- if you don't
8 mind -- we are going to take a couple of
9 minutes break just to make sure that the
10 mikes are functioning with the panelists and
11 we will begin promptly by Governor Deval
12 Patrick followed by Senate President Murray.

13 Thank you for your patience. We
14 will be two more minutes.

15
16 (Short Pause.)

17
18 COMMISSIONER DAVID MORALES:
19 Good morning. We are going to continue this
20 morning's program at the hearing.

21 At this time it is really an honor
22 and pleasure to invite to the podium Senate
23 President Murray.

24 (Applause from audience.)

1 SENATE PRESIDENT MURRAY: Thank
2 you, David. Good morning, everyone.

3 I thank you for inviting me to
4 participate in these very important public
5 hearings.

6 Two years ago this month Senator
7 Richard Moore and I introduced comprehensive
8 legislation to address the rising cost of
9 health care.

10 We made the case that controlling
11 costs increases was essential to our
12 long-term economic growth and the
13 sustainability of our health care reform
14 law.

15 A key piece of that legislation was
16 requirement that the Attorney General and
17 the Division of Health Care Finance and
18 Policy hold annual public hearings to
19 examine health care cost drivers and hold
20 insurers and providers accountable for costs
21 increases.

22 And today represents the first time
23 those required hearings are being held and I
24 want to thank the Commissioner for

1 scheduling them.

2 Health care costs are the No. 1
3 issue facing our economy and the urgency to
4 bring down costs is greater than ever.

5 We are at a crossroads and we must
6 take the path of action -- failure to act is
7 not acceptable.

8 Health spending has reached a level
9 where continued annual increases of three to
10 four percentage points higher than the
11 state's economic growth will increasingly
12 inhibit employers' ability to create jobs
13 and our state and local government to
14 maintain other essential services.

15 In short, health care costs
16 continue to squeeze our state's finances and
17 make it increasingly difficult for young
18 people, families and business, large and
19 small, to make ends meet.

20 Overall Massachusetts spending on
21 health care is 15 percent higher than the
22 rest of the nation. These hearings will
23 help eliminate why this is the case and what
24 the state and insurers and providers can do

1 to slow cost growth.

2 And these solutions can't just come
3 from government alone.

4 These hearings are designed for
5 other voices -- those of consumers,
6 business, business' people, doctors,
7 hospital administrators, insurance company
8 representatives and health policy experts --
9 all offering information and recommending
10 solutions to the cost problem.

11 It is time we get a handle on
12 health care cost drivers which have been a
13 problem for too long even before our
14 landmark Health Care Reform Act of 2006.

15 Health care reform was Step One and
16 as a result more than 97 percent of
17 Massachusetts residents now have coverage.

18 Step Two is Chapter 305 our Cost
19 Containment Law passed almost two years ago
20 which is essential to making sure that
21 health care in Massachusetts continues to
22 move forward.

23 The law attacks costs on several
24 fronts and these hearings are a requirement

1 that will help us identify why we continue
2 to see significant rate increases every
3 year.

4 The Attorney General's preliminary
5 report from January begins to identify some
6 factors associated with premium increases in
7 Massachusetts.

8 It also sheds some light on market
9 inconsistencies and practices by insurers
10 and providers that will help direct
11 solutions and future legislation.

12 Together with the information we
13 uncover from these public hearings, we
14 should get a handle on the complexities of
15 cost drivers and get some answers on how to
16 put the brakes on and start putting costs in
17 the other direction.

18 These hearings are truly
19 unprecedented in both scope and depth and
20 reflect our shared commitment of
21 thoughtfully addressing this complicated
22 issue.

23 And once these hearings are over,
24 we must act quickly and decisively to make

1 the solutions a reality free from
2 bureaucratic red tape and complete with the
3 knowledge and wisdom of people who work in
4 the health care field every day and those
5 most effected by the hardships in increasing
6 costs.

7 The testimony and information
8 presented in the next few days must continue
9 to inform our policy agenda for this session
10 and far beyond.

11 This will be our time to take
12 action and bring relief to families and
13 small businesses while also setting course
14 for long-term payment reform.

15 Thank you, again, for your time and
16 your commitment to this important issue and
17 we look forward and the rest of the
18 legislation looks forwards to results.

19 Thank you.

20 (Applause from the Audience.)

21 COMMISSIONER DAVID MORALES:

22 Thank you, Senate President Murray.

23 Now, I would like to call Secretary
24 Judy Ann Bigby, Secretary of Health and

1 Human Services to the podium.

2 (Applause from the Audience.)

3 COMMISSIONER DAVID MORALES: And
4 I would also like to acknowledge Attorney
5 General Martha Coakley who is with us today.

6 (Applause from the Audience.)

7 SECRETARY JUDY ANN BIGBY: Thank
8 you, Commissioner Morales and thank you,
9 all, for being here this morning.

10 I want to acknowledge your
11 colleagues at the podium, Tom O'Brien and
12 Joe Murphy and also, thank you, Senate
13 President for your leadership in making sure
14 that these hearings actually happened today
15 and in the years to come and thank you,
16 Attorney General, Martha Coakley, for your
17 partnership and dedication in making this
18 happen.

19 I appreciate the opportunity to
20 address you today as we come together to
21 address a critical challenge of the rising
22 health care costs.

23 As the Senate President said, now
24 is the time to really address this because

1 we have achieved near universal coverage in
2 Massachusetts with 97 percent of the
3 residents with insurance.

4 While this is an amazing
5 accomplishment, we must move forward to
6 improve both the quality and affordability
7 of health care so we can maintain and
8 improve access to care.

9 So this is not just about
10 containing costs. It is about making sure
11 that we maintain access and that we are
12 providing the highest quality of care that
13 we can provide to residents of
14 Massachusetts.

15 Simply put, we must restructure the
16 system of delivery to a high value health
17 care system that is less costly, more
18 efficient, more equitable and produces
19 better health outcomes.

20 During these hearings we are likely
21 to hear many perspectives about the problems
22 that create high health care costs and how
23 to address them.

24 I suspect that much of what we hear

1 we have heard before but this is the first
2 time that we will all be presented in a
3 comprehensive manner.

4 We all will understand why we have
5 soaring health care costs and how they are
6 barriers for individuals and businesses.

7 And this is the time that we need
8 to address this problem as we are attempting
9 to rebuild the economy in Massachusetts.

10 Recently the Governor made
11 recommendations about ways to address the
12 costs, the rising costs for small
13 businesses, but we know that these are not
14 long-term solutions and that we must move on
15 to help bring insurance costs under control
16 for businesses, but also make health care
17 more affordable for individuals and for
18 government.

19 As the Governor noted in his
20 testimony last week to the Joint Committee
21 on Health Care Financing and Community
22 Development and Small Businesses, these
23 steps are simply a jumping off point for
24 reforms that will bring long-term solutions.

1 As such these hearings represent a
2 critical juncture for cost containment
3 conversations in the Commonwealth.

4 One of the features of our health
5 care system that is a barrier towards making
6 a more efficient system of delivery is the
7 way we pay for health care and I hope that
8 the dialogue that takes place over the next
9 few days will address this critical and
10 complex issue and explore the ways that we
11 can move from a fee-for-service payment
12 system in which doctors and other providers
13 are paid for each service they provide and
14 is increasingly seen as a barrier to
15 effective, coordinated and efficient care.

16 Fee-for-service rewards, the
17 misuse, overuse and duplication of services
18 and favor costly specialized treatment over
19 preventative and primary care.

20 Primary care physicians,
21 psychiatrists and others who I call who
22 deliver bread and butter medicine have
23 gotten the message.

24 Their services are not as valued as

1 of those of specialists and it is reflected
2 in the stories we hear about barriers to
3 access to care.

4 Changing the way we pay for health
5 care by moving away from a primarily
6 fee-for-service system is the only way we
7 can achieve transportation to a better
8 system of care and one that ideally lowers
9 the rate of growth and health care costs.
10 Incentive should support full vertical and
11 horizontal integration of providers and
12 services with patients having access at
13 multiple connected points.

14 Care is more coordinated for
15 patients who seek it for more organized
16 delivery models such as an integrated
17 delivery systems and physician practices
18 that are based in the primary care
19 centered -- a patient-centered primary care
20 medical home.

21 Delivery of care within among
22 provider organizations and insuring care
23 coordination across the sites of care
24 especially from when transitioning from the

1 hospital to other centers should also be a
2 key objective of system redesign.

3 I urge you to consider effective
4 payment reforms that will push the system
5 away from disorganized poorly coordinated
6 and inefficient care away from care that may
7 not take into consideration patient
8 preferences resulting in unnecessary and
9 unwanted procedures and innovations, away
10 from policies that result in an undersupply
11 of primary care providers and an oversupply
12 of other specialists and away from care that
13 is delivered without attention to clinical
14 science.

15 Failure to take immediate and
16 lasting action will result in continually
17 rising health care costs which will continue
18 to burden not only our state's individuals
19 and businesses but also state government.

20 Thank you very much for your
21 attention to this and I look forward to
22 seeing the outcomes from this several day
23 process.

24 (Applause from the Audience.)

1 COMMISSIONER DAVID MORALES: Now
2 it is my honor to invite to the podium, His
3 Excellency, Governor Deval Patrick.

4 (Applause from the Audience.)

5 GOVERNOR DEVAL PATRICK: Thank
6 you very much.

7 Thank you, Commissioner Morales and
8 Commissioner Auerbach, I think is coming
9 soon, Commissioner Murphy, General O'Brien,
10 General Coakley, Secretary, thank you all,
11 thank you members of the panel, Ladies and
12 Gentlemen. I am going to be very brief and
13 to the point.

14 Since the implementation of health
15 care reform in Massachusetts, you all know
16 we have made incredible strides in ensuring
17 access to health care.

18 Today over 97 percent of our
19 residents have health insurance today. Not
20 another state can touch us.

21 By any measure, it has been a
22 remarkable achievement but like every other
23 state and locality, health care costs
24 continue to rise and to rise sharply.

1 It effects our economic growth, the
2 stability of local communities and our
3 ability to continue to lead the nation in
4 health care.

5 Soaring health care costs rising
6 far in excess of medical inflation are
7 especially hard on small businesses,
8 preventing growth at the moment we need it
9 most.

10 Companies with fewer than 50
11 employees make up 85 percent of businesses
12 in our Commonwealth. They are the
13 undisputed engines of new job creation and
14 economic development but small business
15 owners are paying 74 percent more in monthly
16 premium costs than they were just a decade
17 ago.

18 Since 2001 the median cost of
19 health care for an individual employee has
20 increased by 76 percent.

21 Year after year small businesses
22 and their employees have been
23 disproportionately hit with double digit
24 health insurance premium increases. The

1 payers and providers in the health care
2 industry are as smart and as creative as
3 they come. They have participated
4 constructively in developing long-term
5 responses to these issues but without a
6 short-term solution our economic recovery is
7 in jeopardy and on that score, the response
8 of the industry has frankly been lacking.
9 The situation is stark.

10 If health care costs for small
11 employers are not contained, they cannot
12 create jobs. If they don't create jobs, we
13 will have no economic recovery.

14 Our opportunity, indeed our
15 responsibility, right now is to work
16 together towards a simple goal -- lower
17 health care costs for small businesses and
18 working families in Massachusetts.

19 If we fail to act, the job growth
20 we need right now will slowly suffocate.

21 Last week I testified in front of
22 the Joint Committees on Health Care
23 Financing and Community Development and
24 Small Businesses. The Senator is here and I

1 thank you, again, for that hearing.

2 We testified about our regulatory
3 and legislative proposals to provide
4 immediate health care cost relief to small
5 businesses throughout the Commonwealth.

6 Proposals including all oversight
7 of health insurer and provider rates to
8 protecting small businesses from rate shop
9 will help bring health insurance costs under
10 control. These measures are intended to be
11 temporary in nature to help us through the
12 current emergency but, as I noted then, we
13 need you to address the fundamental reasons
14 health care costs keep going up.

15 To that end, the Payment Reform
16 Commission has made serious recommendations
17 about changing the way we pay for health
18 care.

19 Today's model based on fee for
20 service as the Secretary was describing a
21 moment ago too frequently leads to higher
22 spending and inefficiencies as we reward in
23 effect for the amount of care delivered.

24 If we want to tackle the problem at

1 the core as the Commission proposed, we need
2 to consider a system that rewards the right
3 care in the right place at the right time.

4 Inputs and cooperation from leaders
5 across the industry and in government and in
6 business have produced these important
7 recommendations and I commend them to you
8 for your consideration.

9 I want to the respectfully caution
10 you against being defeated by the complexity
11 of this issue. It is indeed complex. There
12 is no doubt about it. But after years of
13 circular conversation with industry leaders,
14 the cost burden on small business and
15 working families has just gotten worse. We
16 need payment reform implemented carefully
17 and methodically to get us a long-term fix.
18 We also need interim cost containment
19 measures such as we have proposed as a
20 bridge from here to there.

21 I urge you to support both. Thank
22 you very much for having me.

23 (Applause from the Audience.)

24 COMMISSIONER DAVID MORALES:

1 Thank you, Governor.

2 At this time I would like to invite
3 Chairman of the Health Care Finance
4 Committee in the Senate, Chairman Moore.

5 (Applause from the Audience.)

6 SENATE CHAIRMAN MOORE: Thank you
7 very much, Commissioner. And I, like the
8 President, I am also pleased to have been
9 invited to provide some remarks this morning
10 as we begin these really historic hearings.

11 Massachusetts, based on our
12 landmark health care reform efforts is the
13 highest rate of residents for health
14 insurance in the country. However, it would
15 be premature for any of us to raise the
16 mission accomplished manner over the golden
17 dome.

18 Our mission will not be
19 accomplished until we can proclaim that the
20 health care that is delivered -- that this
21 insurance lives us up to our region's
22 representation for the highest quality
23 health care while ending our reputation for
24 the highest cost of health insurance.

1 Frankly, small businesses, which
2 are the economic engine of America and
3 Massachusetts, are not especially impressed
4 by the 97.3 percent of Massachusetts
5 residents with health insurance.

6 The percentage figure that
7 increasingly grabs their attention is the
8 doubts digit increase year after year in
9 their insurance cost. They won't be
10 cheering for the raising of any mission
11 accomplished unless the sign on their own
12 business is flipped to open and their bottom
13 line is in the black.

14 However the rapidly increasing cost
15 of health care in this state makes the goal
16 of small businesses to stay open and our
17 goal of successful health insurance reform
18 increasingly elusive.

19 They are seeing rate increases of
20 25 percent, 40 percent or more and too often
21 those additional costs come right out of
22 their own wallet.

23 Combined with the financing of a
24 child's education, meeting a looming

1 mortgage payment, increasing food and
2 utilities costs, health care costs for the
3 employer and his or her employees make the
4 cost of doing business in retaining workers
5 or hiring new employees extremely daunting.

6 According to a recent report by the
7 Commonwealth Fund, a nonprofit health care
8 foundation, the cost is severe. In 2008 the
9 average premium for plans offered by
10 employers in Massachusetts was \$13,788.00
11 which was 40 percent higher than in 2003.

12 Comparatively, the nationwide
13 premium increase was 33 percent. As policy
14 makers, we need to be concerned about
15 keeping the costs of health insurance closer
16 to the national average if we are to remain
17 competitive with other states for jobs and
18 economic growth.

19 If we continue to overlook the
20 small business owners and those individuals
21 teetering between employer-sponsored
22 insurance and state-offered plans, our small
23 businesses will continue to feel the
24 pressure and burden of sharply rising costs

1 and our economic recovery as the Governor
2 suggested, would be far more difficult to
3 achieve.

4 The Division of Health Care Finance
5 and Policy has confirmed the Commonwealth
6 Fund's findings: Premiums for employers
7 with 50 or fewer insured workers grew faster
8 than premiums for mid-size or large
9 employers with 500 or more covered
10 employees. This means that without
11 significant cost reforms an annual family
12 premium in Massachusetts will soar to an
13 unfathomable \$26,730.00 by 2020.

14 Business owners are not unlike
15 their employees. They struggle and they
16 take home less and make sacrifices necessary
17 to stay afloat but for those of businesses
18 that have been fortunate to remain afloat,
19 rising premiums may well be their perfect
20 storm. By being partners in care, partners
21 for success and partners against failure and
22 partners in recovery, we may be able to
23 provide the lifeline that is necessary for
24 these small businesses.

1 Consequently, the first goal of
2 these hearings must be to aggressively and
3 immediately address the rise in small
4 business health insurance costs.

5 The Division of Health Care Finance
6 and Policy reports demonstrate that the
7 engines of our local economies are bearing a
8 disproportionate share of health care costs
9 and increases.

10 I have struggled to understand this
11 alarming trend especially considering that
12 the Commonwealth stands nothing to gain from
13 permitting innovation or new employment to
14 be stifled, particularly in such a crucial
15 sector of our economy.

16 It is, therefore, my hope that
17 these important hearings produce
18 recommendations for the immediate relief and
19 stabilization of premium increases so we may
20 set the foundation for sound economic
21 recovery -- a recovery that no doubt will
22 largely be driven by our small businesses.

23 While central concern for the
24 hearings that begin today may be the

1 immediate relief for the small group market,
2 we must also begin to focus our attention
3 and action on long-term systemic change of
4 our health care system, and the resources
5 that we devote to it.

6 The effort which we have labeled
7 "payment reform" has the potential to
8 transform our dysfunctional delivery and
9 payment system from that which rewards
10 volume and complexity, into one that rewards
11 quality and value.

12 In doing so, we will be able to
13 control the growth of health care costs, not
14 only for small businesses, but for all
15 businesses, individuals and even government.

16 In the process, we will also be
17 able to create a more coordinated,
18 patient-centered system for the consumer
19 such as the Secretary described.

20 Economists tell us that
21 Massachusetts is a high cost of living
22 state, but that should not be a reason for
23 us to accept higher medical costs that are
24 not explained by high quality care. My

1 colleagues in the legislature and I cannot
2 tell our constituents, many of whom are
3 middle class families, that just because
4 they live in Massachusetts, they have to pay
5 more for their health care.

6 It is even more difficult to
7 confront that reality when those same people
8 are struggling to make ends meet in this
9 brutal economic climate.

10 Frankly, the current system fails
11 those individuals or families who aren't
12 eligible for premium assistance or Medicaid
13 we must pledge today to do better for them.

14 Some misinformed pundits claim that
15 the Massachusetts Health Reform postponed
16 the need to improve quality and contain
17 costs for the sake of addressing access.
18 Considering that I helped to craft Chapter
19 58 the Acts of 2006 and its companion
20 legislation, Chapter 305 of the Acts of
21 2008, I can attest that cost and quality
22 have always been part of our reform efforts.

23 However, expanding access to care
24 can be achieved much more rapidly and

1 produce tangible results more quickly
2 compared to the more difficult time
3 consuming and complex tasks of improving the
4 quality care of care and reducing costs.

5 From Day One, with the historic
6 passage of Chapter 58 in 2006, we set a
7 clear message that no reform would be
8 complete or successful without striking a
9 balance between access, quality and cost.

10 Some of the efforts obtained within
11 Chapter 58 to address quality and cost
12 include -- establishing the Commonwealth
13 Connector Authority with the authority to
14 establish rules for meaningful health
15 insurance coverage and contain costs;
16 establishing the Massachusetts Quality and
17 Cost Council to measure and compare provider
18 costs and lead quality improvement and cost
19 containment efforts, linking hospital rate
20 increases to adherence to national quality
21 standards, initiating a computerized
22 physician order entry program to advance
23 health information technology adoption to
24 better coordinate care and reduce errors.

1 And the list goes on, ranging from promoting
2 wellness and prevention to encouraging the
3 use of primary care physicians as opposed to
4 the more costly Emergency Department use.

5 The passage of Chapter 58 was never
6 intended to be a silver bullet that cured or
7 ailing health care system. It was always
8 our intention to set the stage for more
9 targeted reform efforts, which includes
10 specific cost and quality measures, and
11 eventually a complete overhaul of our
12 payment system.

13 With the passage of Chapter 305 in
14 2008, we provided additional and enhanced
15 policies to further, and more explicitly
16 address the cost and quality components of
17 health care reform which include,
18 establishing the Massachusetts eHealth
19 Institute and providing significant state
20 support for meaningful use of health
21 information technology, which includes
22 establishing goals and timetables for
23 physician competency in that use, initiate
24 reforms to standardize bill coding to reduce

1 administrative expenses; establishing
2 programs to expand the number of primary
3 care providers that sits through a larger
4 class at the state medical school, financial
5 aid for primary care providers, expanded use
6 of nurse practitioners and physician
7 assistants.

8 Establishing strength and
9 guidelines for the determination and need
10 for expansion of health care facilities and
11 that list goes on as well ranging from the
12 establishment of the recently completed
13 commission on payment reform to mandating
14 this very hearing that I have the privilege
15 to address today.

16 Of course, not all of these
17 accomplishments have been fully implemented
18 either because they take time to establish
19 effectively and correctly or they cost money
20 which we all know is a little scarce these
21 days.

22 However, the legislature sent a
23 clear message regarding its priorities and
24 what it believes are the necessary

1 ingredients in any successful and
2 sustainable health reform effort.

3 As I said at the outset of these
4 remarks, our work is not complete. Our
5 mission is yet to be accomplished. Many
6 areas of our health care system are in dire
7 need of reform and any attempt to do so will
8 not be without controversy.

9 In fact, the idea of moving to a
10 global payment system is so controversial
11 and so time consuming that the Special
12 Commission on Payment Reform recommended
13 phasing it in over five years.

14 Equally as controversial is the
15 notion of medical malpractice reform, which
16 drives the costs of wasteful, defensive
17 medicine and far too often produces little
18 or no justice for victims.

19 There are several other areas
20 where, if addressed, we may realize
21 significant savings and produce additional
22 transparency throughout our system.

23 Research into provider-payer
24 contracts has revealed and through the good

1 work of the Attorney General, that
2 regardless of quality, the market share
3 alone can drive skyrocketing costs. Other
4 reports have shown that limits on insurance
5 companies' administrative costs and profits,
6 or changes in the way doctors and hospitals
7 are compensated can produce better quality
8 care outcomes at significantly less cost.

9 According to the Commonwealth
10 Fund's report, doing so may produce a
11 savings of two to three trillion dollars
12 nationally suggesting a potential savings
13 for Massachusetts in the hundreds of
14 millions of dollars.

15 These issues must be considered and
16 we must engage in a debate to find the best
17 outcomes.

18 Neither Chapter 58 nor Chapter 305
19 were drafted or passed by the legislature
20 over night. They underwent careful review
21 and were the product of selfless compromise
22 and negotiation from all of the players in
23 the health care field.

24 However, the small businesses and

1 individuals facing double digit premium
2 increases across our state cannot wait until
3 the next month, never mind until the next
4 legislative session.

5 The Governor and the Senate have
6 both proposed interim measures that would
7 cap growth in provider costs and premium
8 increases. Nobody has claimed that these
9 are the best solutions or that they are even
10 sustainable as long-term solutions.

11 In fact, such caps over time shift
12 cost to other parts of our economy and
13 reduce choice sometimes compromising quality
14 in the delivery of care. However, if we
15 continue to force businesses to choose
16 between paying for health care for their
17 employees and keeping their doors open,
18 Massachusetts will never see true economic
19 recovery and job growth.

20 Of course, small businesses are not
21 the only sector suffering from overwhelming
22 premium increases. I constantly talk to
23 constituents whether elderly, unemployed,
24 college graduates just entering the

1 employment market or hopeful retirees
2 desperately seeking a way out. Recently
3 senior citizens have expressed genuine
4 anxiety over increases in their Medicare
5 supplemental insurance.

6 Individuals, businesses of all
7 sizes and even government at local, state
8 and national levels have expressed growing
9 alarm at rising health care costs.

10 Each and every story adds proof to
11 the maxim that nobody is immune to harm from
12 a faulty system and something must be done.
13 As such, the legislature's urgent hope for
14 these hearings is two-fold.

15 First we hope to gain a better more
16 comprehensive understanding of the pressures
17 driving the cost of delivering care and the
18 rising price of the insurance to pay for it.
19 Secondly, we hope that all providers which
20 include acute care hospital, physicians,
21 skilled nursing facilities, pharmacies,
22 allied health fields and all payers,
23 including insurance companies, health plans,
24 government agencies, self-insured companies,

1 and individual citizens, will tell us what
2 they are doing and will do to reduce the
3 costs of care without sacrificing universal
4 access or without sacrificing improvements
5 in quality of care.

6 As I mentioned earlier, we are all
7 partners, whether it be in success or
8 failure. Hopefully, we can be partners in
9 achieving high quality health care at an
10 affordable level for everyone in the
11 Commonwealth.

12 Some may argue that the task is too
13 daunting, but I look forward to joining with
14 everyone here today and in the hearings over
15 the next several days rolling up our sleeves
16 and getting to work.

17 Senate President Murray and I look
18 forward to the findings and recommendations
19 of these transparency hearings this year and
20 the annual hearing that will follow in the
21 years to come as we continue to steer the
22 ship in the right direction towards better
23 quality and costs as well as access to
24 everyone.

1 Thank you.

2 (Appause from the Audience.)

3 COMMISSIONER DAVID MORALES:

4 Thank you.

5 At this time I would like to invite
6 the Chairwoman from the House of
7 Representatives of the Health Care Finance
8 Committee, Harriett Stanley.

9 (Appause from the Audience.)

10 REPRESENTATIVE HARRIETT STANLEY:

11 These remarks are so typical and I am going
12 to borrow, quote, the Governor's opening
13 words from his testimony before the Health
14 Care Financing Committee last week, the
15 Governor's words were "enough is enough" and
16 my paraphrase is simply enough.

17 We finally have enough data and I
18 have been thinking this morning I have been
19 associated in some way with eight different
20 administrations in the Commonwealth and the
21 work done by the AG's office is probably the
22 best I have ever seen in eight
23 administrations.

24 We finally have enough studies.

1 They stand about that high on a table in my
2 office and we are beginning to have enough
3 analysis -- so again, enough, we need to get
4 going and this morning is a good time to
5 start.

6 Thank you.

7 (Applause from the Audience.)

8 COMMISSIONER DAVID MORALES:

9 Thank you.

10 I would like to now invite -- I am
11 honored to invite actually, the Vice
12 Chairwoman of the Health Care Finance
13 Committee, Mary Grant.

14 (Applause from the Audience.)

15
16 VICE CHAIRWOMAN MARY GRANT:

17 Thank you, Commissioner and to all of you
18 who serve on this panel and address this
19 weighty issue.

20 I particularly wanted to come here
21 today because I had a message that I felt I
22 needed to deliver. So I will put it in
23 context.

24 I am the Vice Chair of the Health

1 Care Financing Committee. I am also a
2 Registered Nurse. I have a Master's Degree
3 in Community Health Nursing. I have served
4 30 years in the clinical field working for
5 the Department of Mental Health, seven
6 years, that was here in Boston in the mental
7 health center writing children's service
8 programs, seven years in Cape Ann running a
9 sexual abuse treatment service out of a
10 criminal justice grant. All of my clinical
11 experience has been in the community
12 setting.

13 I also have had my own practice for
14 14 years and of those 14 years I spent five
15 years doing my own billing so I have the
16 experience of not only the details of
17 billing but also the issue of arguing for
18 payment and rejections and whole the system
19 that goes on. I am in the area of mental
20 health which is a little different.

21 You sometimes have to do a little
22 more arguing for what you want to do because
23 things aren't classic often or they are not
24 often run in the main stream of the health

1 care system.

2 So I have three comments that I
3 wanted to make today as you deliberate the
4 testimony that is coming up over the next
5 three days -- impressive panels, very
6 thorough, but let me start by stating I know
7 these hearings are prescribed legislatively
8 that they have to have annually.

9 I happen to think that this year we
10 are in the position where there is the issue
11 of the day nationally and what happens and
12 what we do with the rich information that we
13 can get in the next three days of testimony
14 and what we do with it will impact I believe
15 not only the citizens of Massachusetts but
16 also what happens nationally if we do it
17 right.

18 Secondly, we have come as several
19 people have mentioned to the limit of our
20 ability to pay as we are now being charged.
21 We can't do it. People can't do it.
22 Businesses can't do it. Institutions are
23 struggling -- every single part of the
24 system is. We have known it for a long

1 time. This isn't new. It has clearly come
2 to a head.

3 The big black hole of where all of
4 these extra charges are going has to be
5 defined and explained in context with
6 transparency, transparency and clarity if we
7 are to move forward on the issue. If we
8 can't do that, we can't move forward.

9 We have taken care of all of the
10 edges of this elephant and we have not gone
11 at the belly of the beast and that is my
12 third message.

13 Payment reform commission made a
14 proposal to start this. My greatest concern
15 in any large effort like this is that
16 clinical practitioners have an equal part at
17 the table in deciding how this money should
18 be spent.

19 We continue to weigh councils,
20 commissions -- whatever -- I have to now
21 read because I can't see any longer, with
22 insurance representatives and institutional
23 administrators, agency representatives all
24 with wonderful perspectives but when the

1 doors close, there is also no pure clinical
2 voices -- a voice that actually knows what
3 the impact will be on the physical health of
4 our general public to move billions of
5 dollars from one part of a payment system to
6 another.

7 We have made this mistake several
8 times over the past 25 years and so changes
9 that we have attempted to make have not held
10 because they aren't clinically sound. They
11 don't work in the office. They don't work
12 for patients and they don't work for people
13 like myself who are delivering the service
14 because they would not be what you would
15 decide to do clinically.

16 So people work very hard in the
17 clinical system to adjust the service that
18 they are delivering to try and help a
19 patient use their insurance benefits. This
20 is a very backward way of working and it is
21 absolutely not the most effective way to use
22 our money.

23 Often times if a person who runs an
24 institution has a clinical degree and serves

1 on those panels, that is a big help.

2 We happen to have a Secretary of
3 Health and Human Services who has been a
4 practicing physician -- that is a very
5 helpful thing and a very helpful perspective
6 but, unfortunately, sometimes when one is in
7 charge of an institution and holds that
8 clinical degree, they have a double loyalty
9 here. One is to protect the institution --
10 it isn't always to make sure that the care
11 that goes to the patient is the most
12 effective or efficient so we have to keep in
13 mind that the active practitioners are who
14 needs to be part of this conversation.
15 People who see patients coming in the room.

16 And it took me, for instance,
17 several years to get Chapter 58 to reflect
18 that there must be in the legislation that
19 there must be at least one practicing
20 clinician on the Quality and Cost
21 Containment Council.

22 When we passed Chapter 58, that is
23 what I thought was one of the most important
24 parts of the bill because I knew access and

1 affordability was important because
2 everybody had to be in the pool or nobody
3 was going to discuss money.

4 Now that everybody is in the pool,
5 we are all talking about money as we should
6 be.

7 One out of those 16 people are
8 required to by law to be a practicing
9 clinician. We happened to have lucked out
10 because by the nature of the position they
11 hold we have had some other clinical input
12 in those discussions but we haven't
13 protected that.

14 When we did the Payment Reform
15 Commission, there was one clinician out of
16 12 sitting on there.

17 I just say this because we would
18 not have institutions delivering health care
19 nor would we have any products for insurance
20 companies if we didn't have the clinicians
21 because there wouldn't be anything to sell
22 insurance for and there would be nothing
23 happening inside of the buildings.

24 They are the ones that have

1 educated themselves for many years in
2 determining what actually works for us.

3 I want to, as I close here, I want
4 to give two concrete examples of how this
5 happens and then just pull it together.

6 We talk about case management as we
7 look forward. We talk about medical home to
8 coordinate care. Everyone talks about this
9 including insurance companies -- that is the
10 most effective way to do it but, for
11 instance, and this is a little "for
12 instance" but it is part of the issue.
13 There is refusal to pay for collateral
14 contacts.

15 Now Medicaid did this as well in
16 the mid '90s. They stopped after two or
17 three years because collateral contacts is
18 how you manage cases and if you can't do
19 that, then you can't manage.

20 Secondly, it is other issues of
21 things we cut out. For instance, an ongoing
22 issue that has gone on for as long as I have
23 been practicing, is and I got a repeat call
24 about an ongoing issue of a school-aged

1 child who has exhibited several neurological
2 symptoms which clearly will impede their
3 ability to learn as they go along through
4 school. But they don't have to, okay, if
5 paid attention to but they would without
6 understanding them.

7 A pediatrician refers the child for
8 a neuropsychological evaluation as the child
9 begins school. The insurance company
10 refuses to pay.

11 These are not little insurance
12 companies. These decisions come from our
13 big insurance companies.

14 Refused to pay -- we don't cover
15 that -- how does that get decided? Does it
16 get decided by cost alone? Does anyone
17 making that decision know the impact?

18 A neuropsychological evaluation for
19 a kid in that instance has often been the
20 blueprint for that child's success for his
21 entire 12 years in school.

22 And if that blueprint is wrong at
23 the beginning, they can go through four or
24 five or six years in elementary school and

1 not understand why they are not learning.

2 So these kinds of things are the
3 blueprint.

4 I have argued many times over the
5 years for why that has to happen and
6 clinically why that has to happen and still
7 I am in this is position still getting calls
8 about the refusals happening.

9 It is put off and put off and then
10 the answer this week I got was I understand
11 the school system is going to do an
12 evaluation -- okay, here is an issue of
13 money -- let's track the money, school
14 systems to do evaluations -- some very well,
15 the evaluations are geared towards learning
16 only.

17 When a pediatrician refers for a
18 neuro psych evaluation for school age, this
19 isn't just about learning. It is about life
20 functioning as well as learning and the two
21 are not the same.

22 So after a year of fighting, first
23 of all, one is more -- I told you that one
24 is more heavily learning oriented, secondly

1 the situation clearly to me on some level
2 looks like the cost avoidance for an
3 insurance company moved over to a public
4 school but the saddest part of all is this
5 child and this happens all of the time has
6 lost a year of intervention at a critical
7 point in their life.

8 So as I, in summary, I guess my
9 messages are please actively listen to all
10 of this. We can't have a big impact if we
11 get it right.

12 Secondly, we have to remove the
13 veils within the system that clouds our
14 vision and prevents us from getting it right
15 for the general public and patients.

16 Thirdly, ensure a strong clinical
17 voice at a decision table to ensure that
18 billions of dollars are clinically
19 effective.

20 Without this, it does not matter
21 what the balance sheet looks like as we will
22 be leaving a less functional citizenry.

23 Thank you very much.

24 (Applause from the Audience.)

1 COMMISSIONER DAVID MORALES:

2 Thank you.

3 Are there any other elected
4 officials that I may have missed in
5 attendance?

6 (No Response.)

7 COMMISSIONER DAVID MORALES: All
8 right, what I would like to do very briefly
9 is 1, go over today's agenda again and talk
10 a little bit about process and, again, to
11 update everybody from this morning's
12 introduction, we are going to move onto
13 health care finance and policies and
14 research experts to have them briefly walk
15 through their findings, after that at 11:15
16 we will have Commissioner Murphy speak to
17 his findings and some of the research that
18 he has done through his hearings and then we
19 will go on at 12:00 to hear from Len
20 Nichols, a nationally respected health care
21 economist and then we will have a half hour
22 break or so for lunch at 12:45.

23 Around 1:15 we will have Attorney
24 General Martha Coakley and have her review

1 her presentations and her finding with her
2 team so her team will do an employer panel
3 and then around 3:30 a consumer panel and
4 lastly the last point I want to make to make
5 is just to make sure that everyone if
6 interested engage today.

7 So you will see some members of my
8 team going around that will have index cards
9 that you can write your questions on.

10 As you listen to the testimony, to
11 the presentations -- if you feel the need or
12 the interest and I encourage you to raise
13 your hand and we will distribute some index
14 cards for you to write your questions and
15 the Moderator in this instance, Stan
16 Wallack, will handle and select which
17 questions to ask.

18 So, Professor, if you will, please,
19 Stan Wallack.

20 (Applause from the Audience.)

21 PROFESSOR STANLEY WALLACK: Thank
22 you, Commissioner, and good morning.

23 I have met some of you over the 30
24 years I have been at Brandeis.

1 But most of these social and health
2 policy gatherings -- 30 years ago Brandeis
3 became the first outside cooperative
4 research department for Medicare. As a
5 result, I have conducted numerous studies,
6 developed demonstration for Medicare,
7 designed payment systems for the medical
8 government and while small actions, the
9 Federal government can make huge impact or
10 chaos, I have come to become more attuned
11 with Judge Louie Brandeis' belief that
12 states are the laboratory for real change in
13 this country and early in my career also as
14 a Federal Government official, I often made
15 policy based on some observations, personal
16 observations about what works.

17 Some of you, particularly my wife,
18 Anya Rader Wallack, who some of you know,
19 may say that the reason I became so
20 interested in state health policy is because
21 of her passion. I can't argue completely
22 with that but the reason I have become
23 interested is because I believe we can make
24 a difference starting in one place.

1 An example of that is one of the
2 Brandeis demonstrations through Medicare was
3 the physician group practice demonstration
4 which has now become morphed or changed into
5 the model for the accountable care
6 organizations.

7 We put the backbone together for
8 doing that model, the share savings model,
9 setting up quality standards, etc., and that
10 has become so successful in its own small
11 limited way that now people are looking at
12 the accountable care organization as a
13 viable alternative to bring about for the
14 whole country.

15 (Discussion off the record.)

16 PROFESSOR STANLEY WALLACK: The
17 reason why Brandeis decided to be a
18 strategic partner for the Commonwealth,
19 understanding the determinants of health
20 care cost and cost drivers and assist them
21 for developing policy solutions is really
22 because of the importance of the issue.

23 This is actually the first state
24 project in my whole time as a health policy

1 expert and analyst that I have ever done a
2 state project and I know that addressing the
3 cost growth cannot be done in a piecemeal
4 fashion by some part of the health system.

5 We all talk about this balloon you
6 press it in on one side and it comes out the
7 other side.

8 States I think do hold the promise
9 for being the right level for being the
10 coordinator of cost containment and just as
11 Massachusetts has led the country on
12 universal coverage, this is the state that
13 can lead the way for the country to cost
14 containment.

15 Health care cost growth is a
16 challenge for the whole country. You have
17 heard that from our speakers today, the
18 officials.

19 Moreover, the states hold, I think,
20 economists as being, you know, as I said
21 before, the right level for moving forward.

22 As you will see today, our cost
23 growth and the urgency for Massachusetts is
24 even greater.

1 We have higher costs and we have
2 higher cost growth.

3 When the Massachusetts Universal
4 health care plan was passed, it was the
5 general expectation that cost containment
6 would follow as the next step for the very
7 simple reason we heard today.

8 That if costs growth continues to
9 exceed the growth in the economy that the
10 state could not be reformed and it could not
11 be sustainable for the Commonwealth, for
12 employers or for individuals.

13 Now we are fortunate that we have
14 established a strong working relationship
15 between the private and public sectors in
16 Massachusetts.

17 This is important because lowering
18 the cost trend will require a community wide
19 effort for providers, for policy makers,
20 academics on both what I call as an
21 economist the demand side of the health
22 equation as well as the supplier side if we
23 are going to improve the long run efficiency
24 of the Commonwealth's health care system.

1 Now Chapter 305 created the urgency
2 of cost control -- about cost control and it
3 is even more urgent now with the downturn in
4 the economy as we heard and we can't wait.

5 The legislation required the
6 Division of Health Care Financing to do the
7 same report on spending trends and
8 underlying factors and recommendations and
9 steps toward the end report have been taken
10 already. We have done some of the strategic
11 reports we are going to be talking about
12 firstly this morning.

13 These public hearings are to
14 present the findings that allow the interest
15 of all of the affected stockholders to be
16 expressed.

17 The recommendations are going to
18 follow these hearings and so, really, I
19 support the Commissioner in saying we really
20 want to hear from you.

21 Now there are limitations to the
22 first year's report. First, they only
23 covered the years 2006 to 2008. Secondly,
24 we are able to report what the major cost

1 drivers are but we have not yet had time to
2 analysis some very important questions about
3 why.

4 Over the next two days or three
5 days of hearings we hope to learn a lot from
6 the insight of providers and health plans
7 and individuals about why.

8 And, third, the first year's
9 analysis has been done only with the claims
10 experience of private payers and subsequent
11 studies will add the 2 million individuals
12 that are covered by Medicare and Medicaid.

13 Now the legislature, I think,
14 recognized in saying we should first look at
15 the private sector because that is the big
16 hole as we look at health care costs and
17 that is the one that we had to address.
18 About 60 percent of Massachusetts residents
19 are covered by private insurance. We know
20 little about what is happening in terms of
21 the costs, in terms of the trends.

22 So our first year reports are
23 really based on what is going on in the
24 private sector. And, as I said, in the next

1 couple of years, we will add Medicare and
2 Medicaid, so we will accomplish a complete
3 picture in what is going on in the economy
4 with regards to costs.

5 This study as David Morales has
6 said is done by a team -- a team from
7 Brandeis, Mathematica, Oliver Wyman as well,
8 I should say, we have worked very closely
9 with division staff. They were instrumental
10 in getting these reports done.

11 So what I am going to do in my role
12 as Moderator now is to allow each speaker to
13 present for about 10 minutes and highlight
14 their findings. As you all know on the web
15 there is some long reports there.

16 They are going to try to give you
17 the highlights and the major points that
18 they want to bring home to you.

19 I will introduce them all now and
20 there are short bios provided to you in the
21 folders. You should all look at those. It
22 is a very impressive group today and for the
23 next couple of days.

24 So Cindy Thomas, an Associate

1 Professor at Brandeis will lead off.

2 Cindy was the Project Manager in
3 our role as the strategic leader and as
4 manager of these studies and she is going to
5 do the first presentation looking at the
6 first report which is the context. Let's
7 look at Massachusetts in the context of the
8 whole county.

9 We need to put ourselves -- we need
10 to understand that we are different but not
11 that different but what moves costs
12 generally is what moves costs here.

13 Cindy is going to be followed by
14 Dianna Welch. Dianna is at Oliver Wyman and
15 Dianna is the lead actuary on this spread
16 analysis. Dianna is well known to some of
17 you because since she spent four years at
18 Blue Cross prior to going to Oliver Wyman.

19 The last presenter on the panel is
20 Deborah Chollet. Deborah is a senior fellow
21 at Mathematica and Deborah has led the
22 Mathematica analytical team and has done
23 prior work for the state including being a
24 consultant to the Payment Reform Commission.

1 So Deborah will be the last presenter.

2 We will have the three
3 presentations and then I will begin with
4 follow-up questions, but, again, for the
5 various members here at the head table as
6 well as for the audience, I will be glad for
7 you in the audience to forward your
8 questions on.

9 MS. CINDY PARKS THOMAS: Thank
10 you, Stan.

11 For the better part of this year I
12 have been assisting the Division in
13 preparing health care costs trend reports
14 and I want to thank Commissioner Morales for
15 providing us the opportunity to contribute
16 to this very important effort.

17 I just want to start by
18 acknowledging that any interpretation of
19 data, consideration of recommendations or
20 moving forward towards solutions rests on
21 having a thorough understanding of the
22 strong Massachusetts health care system, its
23 features related to health care costs and
24 cost drivers and a little bit of history and

1 knowing where Massachusetts sits in
2 comparison to the rest of the nation.

3 With that I will briefly review the
4 findings of Part One of the health care
5 costs trends drivers, Massachusetts -- I
6 will make four points today.

7 Massachusetts health spending is
8 higher than the nation.

9 Second, the structure of the
10 Massachusetts health care system is charged
11 by specialization, academic medical centers
12 and open health care networks.

13 Third, methods used by health
14 insurers to pay providers are really mostly
15 all fee-for-service even within managed care
16 organizations.

17 And I will conclude with some
18 places where there are opportunities to
19 provide increased efficiency in the health
20 care system.

21 I would like to just begin by
22 saying Massachusetts health care system is a
23 critical component of the state's economy.
24 It is the largest employer of Massachusetts

1 residents and accounts for over 13 percent
2 of the gross state product.

3 We rank first among states in
4 access of care according to the Commonwealth
5 Fund and seventh among states on overall
6 health system performance.

7 Massachusetts hospitals are often
8 cited as among the best in the nation in
9 terms of quality of care delivered and
10 Massachusetts health plans as we know are
11 consistently rated among the top ten plans
12 nationwide.

13 At the same time we as the rest of
14 the nation are grappling with escalating
15 health care costs consuming a greater
16 portion of the economy and lowering real
17 wage growth as you have already heard this
18 morning.

19 Some of this cost growth is driven
20 by system-wide challenges such as an aging
21 population and greater use of high
22 technology services. Some challenges such
23 as those that stem from the structure of the
24 system and the marketplace are unique to

1 Massachusetts and must be considered as we
2 identify strategies and that is what I am
3 going to talk about.

4 First of all, Massachusetts
5 spending compared to the rest of the
6 nation -- as you can see, the bottom line
7 represents the United States. These are
8 data provided by the National Health
9 Accounts. The state data is only available
10 from 2004 which created a greater challenge
11 for us to understand where Massachusetts
12 lies compared to the rest of the nation as
13 well as really confirms the importance of
14 the findings -- of our research now in
15 identifying health care trends over the past
16 several years.

17 U.S. per capita spending more than
18 doubled since 1992 growing 5.5 percent per
19 year. Massachusetts at the same time went
20 from 22 percent higher health care costs
21 than the nation to about 27 percent.

22 If Massachusetts stays its 27
23 percent in 2008, that means that we would
24 have an average unadjusted per capita

1 spending of \$8,100.00 per individual per
2 year.

3 Some of you have seen more recent
4 health growth trend reports on the national
5 level. This is the first year -- the lowest
6 in many, many years -- the health care cost
7 trends have decreased.

8 One of the estimates is for
9 personal health care it has gone down to 4.4
10 with a cap of 3.7 percent. So we will be
11 curious to see what happens when National
12 Health Accounts updates the state level
13 trends to see where we sit.

14 Well, we are a different system and
15 when you adjust, we take our state spending
16 but when you adjust for the amount of
17 revenue hospitals get that is non-patient
18 revenue that is contributed in terms of
19 research and investment income, we are a
20 little bit less out of scale and then when
21 you further adjust by wage index, we are a
22 relatively high wage state -- the difference
23 decreases to 15 percent higher than our
24 national spending.

1 What is interesting is that
2 hospitals rank 18 percent higher than
3 national but we are really most out of scale
4 with the rest of the nation on home health
5 and long-term care and some of this is
6 because we have expanded community services
7 which is -- which is a good thing, however
8 we still -- it results in our having 25
9 percent higher nursing home utilization and
10 50 percent higher home health utilization.

11 Our higher spendings are not only
12 due to utilization but to prices.
13 Utilization from Massachusetts -- we are a
14 little bit higher in hospital care but where
15 we really stand out is the outpatient
16 services.

17 Now remember this is just
18 hospital-based outpatient services.

19 We do not have a handle yet on
20 non-hospital use but we are 58 percent
21 higher than the nation in outpatient care.

22 I want to underscore the fact that
23 prices are also important. As Medicare and
24 Medicaid have decreased their growth in

1 prices, private payers are paying an
2 ever-increasing portion of hospital costs,
3 and we will see a little bit more of that as
4 we go on.

5 We also as Senator Moore noted, we
6 have higher health premiums -- especially
7 since 2003. We are ten percent higher than
8 the nation -- why is that? One of the
9 reasons is that we have a very generous
10 health care insurance system.

11 At present according to national
12 data we have 38 percent lower deductibles on
13 average than the rest of the nation.

14 Let me talk for a moment something
15 we all know -- the structure of the system.
16 We have 80 percent more specialists and 40
17 percent more general practitioners, more
18 physicians, many more behavioral health
19 specialists also.

20 A moment on academic health
21 centers -- this is a striking statistic we
22 found. We all know that we are heavily
23 dominated -- have a heavy presence of
24 academic medical centers. Academic medical

1 centers, however, account for 45 percent of
2 hospital admissions compared to 19 percent
3 in the nation.

4 There is a huge growth in 1993 to
5 1999 and 2000 when several non-academic
6 centers closed and admissions were moving to
7 the academic centers.

8 However, they make a huge
9 contribution at the same time. I don't want
10 to diminish that. In 2007 the economic
11 contribution of academic centers was over
12 \$4,500.00 per capita.

13 We are -- of the five United States
14 hospitals that receive the most NIH funding
15 in 2005 -- five of the hospitals that
16 received the most funding were in Boston.

17 However, prices at medical centers
18 that are academic centers are higher than
19 non-academics centers which you will see in
20 our trends report.

21 Our insurance system is heavily
22 dominated by PPOs as in the rest of the
23 nation. However, in Massachusetts to be an
24 HMO, you do not have to -- we have more

1 HMOs, but you do not have to pay providers
2 in any certain way, you have can still pay
3 fee for service which as we have heard
4 several times today does not encourage cost
5 containment and I am going to talk for a
6 moment about those methods used by health
7 insurers to pay providers with.

8 In 2009 with support from
9 Mathematica, the Division conducted a survey
10 asking carriers how they pay providers.

11 In general, there is very little
12 capitation. We found four of those no PPOs
13 reported paying capitation. For the HMOs
14 that pay capitation, 16 percent of providers
15 primary care physicians prefer paid
16 capitation and only 5 percent of
17 specialists.

18 Similar statistics exist on the
19 outpatient side. There is very little risk
20 shared by hospitals in outpatient services.
21 It is usually discounted charges or per
22 visit payments.

23 So what to we conclude from this.
24 There is a dominance of a fee-for-service

1 system. We have open networks with limited
2 pressure to decrease prices. General
3 insurance coverage which is great and low
4 cost sharing, however, it doesn't increase
5 utilization services.

6 Greater use of outpatient hospital
7 care in comparison to the rest of the
8 nation. We don't know non-hospital
9 outpatient care yet. It is an important
10 thing to understand where that care -- how
11 much of that care is being provided and
12 where. It is not necessarily being used as
13 a substitute for inpatient care because the
14 inpatient care has not gone down that much
15 commensurate.

16 And we have high ease of academic
17 centers which have higher prices which
18 provides us finally opportunities that we
19 see in comparing Massachusetts to the rest
20 of the nation for creating -- for obtaining
21 greater efficiency while maintaining our
22 high quality system.

23 Well, fee-for-service dominance
24 suggests that payment reform is necessary.

1 Use of more limited networks really warrants
2 consideration. Massachusetts generally low
3 cost share provides a good opportunity to
4 redesign benefits but only in the event that
5 consumers can be educated on using low cost,
6 high quality providers and finally we
7 believe that outpatient hospital care and
8 other services can be moved to less costly
9 setting.

10 And with that, I will turn to
11 Dianna next. And I think we will take
12 questions at the end.

13 PROFESSOR STANLEY WALLACK: We
14 will taken questions at the end.

15 MS. DIANNA WELCH: Thank you.

16 I would like to briefly discuss now
17 the findings from the premium trends section
18 of the analysis that we performed for the
19 Division.

20 What we have found was premium
21 trends of about 7 percent in 2007 and 5
22 percent in 2008.

23 Now it is important to point out
24 that these are the actual premiums paid by

1 individuals and employers without any kind
2 of adjustments down on our part and because
3 of that that means that any shifts in the
4 population over this time period or more
5 importantly shifts in benefits due to these
6 premiums trends, so, for example, if
7 individuals and employers hadn't reduced
8 their benefits over the time period, these
9 premiums trends would have been higher than
10 what we are reporting here.

11 In terms of the components of the
12 premium growth that we showed on the last
13 slide, about 94 to 97 percent of the premium
14 growth over this time period was driven by
15 increases in claims cost. There is a couple
16 of reasons for that.

17 First, claims costs represented
18 approximately 88 percent of the premium
19 during this time period and the claim costs
20 were also growing at a faster rate than the
21 non-medical plan cost -- those being
22 administrative expenses and profit.

23 So the majority of the increase in
24 the premium was driven by the overall cost

1 of medical care.

2 When we look at the average
3 premiums by market segment those being small
4 groups, mid-sized groups and large groups we
5 saw consistently across these three years
6 that large groups were paying the highest
7 premiums amounts and they also had the
8 highest trends over this time period.

9 Now these, again, similar to the
10 previous slides are unadjusted premium
11 amounts and the large reason for the large
12 employers paying higher premiums is that
13 they purchase richer benefits during this
14 time period. They also have totally
15 different characteristics, for example,
16 being more likely to be located in Boston.

17 So in this slide what we have shown
18 is the results of our adjusted premium
19 analysis. So in order to try to account for
20 those differences in both demographics and
21 in benefits, we took the premium data and
22 adjusted it so that small, mid and large
23 sized groups would all be on a consistent
24 and demographic benefit basis.

1 The picture changes a little bit
2 when we do that.

3 Now we see over this time period
4 that small employers had the highest premium
5 trends during this time.

6 Also not shown on this slide --
7 small employers were paying a higher premium
8 amount when we made those adjustments.

9 For example, in 2008 small
10 employers were paying about 5 percent more
11 than mid-sized groups and about 6 percent
12 more than large groups when adjusted to
13 consistent benefits and demographics.

14 I would also note the higher
15 premium trends for small groups during this
16 time period were driven by higher claim
17 costs.

18 What we will see a little bit later
19 is the difference in administrative expenses
20 and profit between small and large groups
21 actually narrowed during this time period.
22 So the larger trend really is being driven
23 by higher increases in medical claims costs.

24 So now we have been eluding to the

1 benefits a little bit already.

2 We will look at the benefits over
3 the study period. This chart is showing the
4 median actuarial value by market segment
5 where actuarial value is a measure of the
6 richness of the benefit plan and here we are
7 showing just the most popular products.

8 So for the most popular product we
9 can see that all group sizes reduced their
10 benefits during the study period. We can
11 also see that small groups had the lowest
12 level of benefits during the study period
13 suggesting that they purchased less rich
14 benefits.

15 And now this slide is only showing
16 the most popular products. If we do look
17 across the average of all products, the
18 picture is slightly different. Mid-sized
19 groups and large groups had very little
20 changes in their benefits while small
21 employers bought down their benefits more
22 significantly particularly in 2008.

23 So now we will look a little bit at
24 the non-medical expenses, the administrative

1 expenses and contribution to surplus or
2 profit.

3 So this slide shows the non-medical
4 spending as a percentage of premium. We
5 have broken down the non-medical spending
6 into administrative expenses, commissions
7 and contribution to surplus which is also
8 referred to as profit.

9 In the administrative expenses we
10 can see that small groups pay the highest
11 percentage of premium for the administrative
12 expenses -- about 7 and-a-half percent
13 compared to roughly leave 6 percent for
14 mid-sized and large employers.

15 This is likely due at least in part
16 to the fact that some expenses are fixed in
17 nature. So, for example, it costs the same
18 amount to send out a bill to a small
19 employer as it costs to send out a bill to a
20 mid-sized employer but that small employer
21 has fewer employees to spread the cost over.
22 So as a percentage of premium, it costs more
23 to administer a small employer group.

24 In terms of commissions, large

1 groups were paying just over 1 percent while
2 the small to mid-sized groups were paying
3 two to two and-a-half percent and we saw
4 contributions and surplus in the two to
5 three percent range during the time period.

6 That resulted in total non-claims
7 expenses ranging from 9.6 percent for the
8 large groups to 12.4 percent for small
9 groups. So we do see that the small groups
10 pay a higher portion of their premiums for
11 these non-medical expenses.

12 This also results in loss ratios in
13 the high 80s to roughly 90 percent which is
14 higher than we typically see in other parts
15 of the country.

16 The growth in the non-medical
17 spending over the study period was quite
18 variable.

19 From 2006 to 2007 we saw increases
20 in non-medical spending for small employer
21 with decreases for mid-sized and large and
22 that trend reversed itself in 2007 to 2008
23 resulting in an average over the two-year
24 period of increases of .3 percent for small

1 groups and up to 4.3 percent for large
2 groups.

3 So while small groups are paying a
4 higher percentage of premiums towards
5 non-medical spending, that non-medical
6 spending was growing at a slower rate and,
7 therefore, the difference in the spending
8 between small groups and large groups
9 actually narrowed during the study period.

10 I will show some preliminary
11 results of the merged market. It was
12 expected when the markets were merged which
13 was effective July 1st of 2007 that
14 individuals would realize lower premiums as
15 a result and, in fact, we did see that as
16 expected.

17 In 2008 individuals in the merged
18 market were paying about a third less than
19 individuals who remained in the pre-merger
20 products.

21 Now, we can't attribute that entire
22 amount to just merging of the market. It is
23 also important to note that this
24 incorporates the fact that individuals in

1 the merged market are purchasing different
2 benefits on average than those that remained
3 in the pre-merger products and may also have
4 a slightly different demographic.

5 Medical expense ratios by market
6 segment -- again, we have seen that over the
7 study period in total the loss ratios have
8 been increasing and have been in the mid to
9 high 80, 80 percent range.

10 Specific to the merged market we
11 saw individuals in the merged market having
12 a loss ratio in 2008 of 112 percent compared
13 to small groups which has an 86 percent loss
14 ratio. So this is suggesting that small
15 groups as expected are to some extent
16 subsidizing those individuals in the merged
17 market resulting in a total merged market
18 loss ratio of 88 percent.

19 This suggests that there is about a
20 2.3 percent impact on small employers of
21 that subsidization in the merged market.

22 Finally, I will point out that all
23 of the previous slides talk about average
24 premiums and average premium growth over the

1 study period.

2 Of course, not many individuals or
3 small employers pay -- or large employers
4 pay the average. There is a very wide range
5 of premium amounts and premium increases
6 that can be experienced in the market and
7 there are several reasons for this.

8 For one, there are several carriers
9 that were included in our analysis.

10 Some carriers will have different
11 rate increases than others. Even within a
12 carrier, they can make changes to their
13 pricing.

14 For example, a carrier may change
15 the rate increase for one given benefit plan
16 in a different way than other benefit plans.
17 In that instance, only those individuals or
18 employers with a particular benefit plan
19 that has been adjusted will feel that
20 increase and there is also changes in the
21 increase that are driven by demographics of
22 the employer group.

23 So while we have reported premium
24 trends of roughly 6 percent over the study

1 period, that is really representative of
2 their being little or no changes in the
3 demographics of the population.

4 A small employer though, for
5 example, if they have a fixed population and
6 they have experienced no turn over during
7 the year, we would expect that when they go
8 to renew their insurance, everybody has
9 gotten one year older -- typically there is
10 5 year age banding in premium rates -- so we
11 would expect 20 percent of employees to be
12 rated up into the next higher premium band.

13 That means if that if there were no
14 changes to the population, instead of
15 getting that average increase of 6 percent,
16 we would expect the rate of increase to be
17 over 10 percent as a result.

18 Other changes in the demographics
19 can result in very different premium
20 increases either higher or lower depending
21 on the changes that were made.

22 And with that, I will turn it over
23 to Deborah to talk about it claims analysis.

24 MS. DEBORAH CHOLLET: Good

1 morning.

2 As Stan Wallack has mentioned the
3 examination of cost trends in this first
4 year is focused only on privately insured
5 plans.

6 The cost trends that I am going to
7 discuss include both the covered benefits in
8 a health insurance plan and the
9 out-of-pocket spending by the insured
10 employee or family of the insured.

11 The main take away points are here.
12 I won't repeat them at the end but you can
13 look to your copies to review.

14 Spending has increased quite
15 quickly in Massachusetts at an average of
16 7.5 percent in 2006 to 2007 and another 7.5
17 percent from 2007 to 2008. That compares to
18 national numbers that are substantially
19 lower.

20 Spending for outpatient hospital
21 care and physicians, other services
22 professional services grew especially fast
23 in Massachusetts.

24 We looked at the components of the

1 spending increases and prices drove spending
2 growth especially for inpatient care and
3 physician and other professional services.

4 In the outpatient setting including
5 outpatient imaging, the spending growth was
6 driven by both volume and increase in the
7 number of services provided and price.

8 Prices varied widely for all of the
9 services we looked at. We looked at major
10 services in various categories and we saw
11 substantial price variation.

12 And finally we looked at hospital
13 readmissions which the Division has looked
14 at before and what is different about what
15 we have done is that we also looked at
16 physician visits within 30 days following
17 readmission and so I will present those
18 general findings.

19 As I mentioned health care costs
20 rose at 7.5 percent in each year we looked
21 at. The national average growth was
22 something less than 4 percent. This is as
23 close as we can get on a system basis.

24 So Massachusetts is well above the

1 national average. This left Massachusetts
2 in 2008 with a privately insured population
3 paying about \$4,500.00 per member per year
4 in Massachusetts which is quite high.

5 And, as I said, that includes both
6 the insured and the out-of-pocket costs.
7 Physician and professional services and
8 outpatient care in Massachusetts represents
9 combined 57 percent of total spending in
10 2008.

11 When you add prescription drugs in
12 at 18 percent and inpatient care at 17
13 percent, those four categories of services
14 combined cover about 92 percent of all
15 spending in Massachusetts.

16 I will come back to that because in
17 fact those categories, the largest
18 categories of physician and other services
19 and outpatient hospital care are also the
20 fastest growing which you see in this slide.

21 I think what is important about
22 this slide is that not only are outpatient
23 hospital and professional and physician
24 professional services rising faster than the

1 average in Massachusetts. They are rising
2 at an increasing rate, that is costs in
3 effect have accelerated in 2007 to 2008.

4 The other important thing to notice
5 is that the only reason that health care
6 spending was as low as it was in
7 Massachusetts and growth was as low as it
8 was was the very slow growth of spending for
9 prescription drugs -- largely related to the
10 adoption of generic drugs and utilization.

11 Absent that pharmacy trend which is
12 you will recall from an earlier slide which
13 is the third largest sector of spending
14 growth, on the average overall would have
15 been much faster and health care costs
16 growth in Massachusetts would have
17 accelerated as opposed to having that even
18 7.5 percent from year to year.

19 I am going to go through the three
20 categories of services -- hospital inpatient
21 expenditures, physician and other
22 professional services and outpatient
23 expenditures including imaging services --
24 now I am thinking about it, not necessarily

1 in that order.

2 Hospital expenditures increased
3 about 9 percent from 2006 to 2007 and about
4 8 percent from 2007 to 2008.

5 The fastest growing segment of
6 those expenditures were for medical
7 inpatient admissions -- second to surgical.

8 You will notice that there is a
9 large drop off in growth for maternity and
10 newborn care and, again, the moderation of
11 spending in inpatient services was largely
12 related to that maternity drop off and I
13 think we can discuss what that is about if
14 you wish.

15 But absent that, the overall growth
16 would have been higher and the slow down in
17 inpatient spending would have been much
18 less.

19 Despite the fact surgical
20 admissions, the expenditures for surgical
21 admissions grew more slowly than for medical
22 admissions. Those surgical admissions are
23 very expensive. They represented more than
24 half, 52 percent of the growth in inpatient

1 care.

2 I am going to take a little bit of
3 time with this slide because you will see a
4 series of others that are similar to this.
5 We created a market basket of spending for
6 each of these service types.

7 The market basket that was created
8 in 2006 and 2007 because there was a bigger
9 claims tail in the later year.

10 And when we were looking at
11 services at this level, we could not adjust
12 for that claims tail but the other spending
13 numbers do adjust.

14 We have no reason to believe that
15 the 2007 to 2008 pattern is much different
16 from this.

17 This market basket includes
18 services that were delivered consistently
19 from year to year so there were no new
20 services popping in and there was a large
21 sample of new services that we could look
22 at.

23 The market basket from 2006 to 2007
24 included over 90 percent of expenditures for

1 inpatient care. We then divided out the
2 impacts of three items on total expenditures
3 that is how much of the growth was driven by
4 increases in prices, how much of the growth
5 was driven by increases in the numbers of
6 admissions for those particular services and
7 how much was driven by the fact that the
8 service mix was changing -- that there might
9 have been more complicated services
10 delivered in 2007 that had been delivered in
11 2006.

12 And you will see the result is
13 price. There is no increased admissions --
14 to the contrary -- there was a drop off in
15 admissions -- there was no increase, no
16 significant increase in the complexity of
17 services delivered -- the difference was in
18 price.

19 Now price itself is a relatively
20 complicated variable. It includes not only
21 the provider in place simply increases
22 prices -- it certainly includes that but it
23 might also include some movement in the
24 system. It would include patients who are

1 seeking out higher priced providers and in
2 this case higher priced hospitals and that
3 would have generated an increase in the
4 prices that we observed.

5 It could also be changes in covered
6 lives among carriers that happen to pay
7 providers higher prices. It is likely to be
8 mostly the first given that there is not
9 that much movement from year to year either
10 in going to different types of providers or
11 moving from insurer to insurer.

12 Outpatient expenditures you will
13 see that the increase in outpatient
14 expenditures not only is high, but that the
15 procedures in imaging, in particular,
16 account for more than half.

17 I think the increase in expenses
18 for imaging services has been somewhat of a
19 surprise in Massachusetts.

20 Sixty-three percent of the growth
21 in spending for outpatient services is
22 associated with this bottom green bars that
23 is teaching hospitals. But teaching
24 hospitals represent overall just 54 percent

1 of expenditures for outpatient services.

2 So teaching hospital growth is
3 significant with respect to the outpatient
4 trends.

5 This is the same kind of slide we
6 have spent sometime on a minute ago taking
7 outpatient service growth and looking at
8 what the impacts have been of price, the
9 number of services delivered and the service
10 mix and you will see that it is both price
11 and the number of services that was driving
12 spending for outpatient services.

13 Did I skip over something? I am a
14 slide behind, I apologize.

15 I am going to move on to imaging
16 services and expenditures for imaging
17 services.

18 You will see that the standard
19 imaging is the largest component and also
20 the fastest growing component in 2006 to
21 2007 followed by echographs and ultrasounds.
22 That pattern reversed itself somewhat in
23 2007 and 2008 and MRIs, MRAs became the
24 fastest growing component of outpatient

1 imaging.

2 What we are looking at here by the
3 way is a combination of the professional
4 services and facility charges.

5 The drivers of spending growth for
6 imaging services again looks very much like
7 overall outpatient -- the combination of
8 price and the number of services provided
9 and there is not an increase in the
10 complexity of services provided.

11 We move on quickly to physician and
12 other professional services. You will
13 recall physician and other professional
14 services is the second fastest growth
15 category after hospital outpatient in
16 Massachusetts.

17 The growth in spending for
18 physician services in particular reflects
19 fast growth in spending for specialist care.
20 Spending for primary care slowed somewhat
21 from 2007 to 2008.

22 While specialists services were not
23 growing the fastest in these years, they do
24 represent growth in spending for specialist

1 services represents more than half of the
2 growth in this spending category overall.

3 In 2007 to 2008, 48 percent of the
4 growth in spending for physician and
5 professional services -- again drivers have
6 changed looking at the contribution price,
7 the number of services, the number of
8 service mix or the amount of changes in
9 service mix, and you will see, again, price
10 is the primary driver of spending growth in
11 this category.

12 We looked at a couple of
13 opportunities -- potential opportunities for
14 improving efficiencies in health care in
15 Massachusetts and particularly we looked at
16 price variations as an indicator of provider
17 market power and in economist's terms,
18 market failure, failure of competition to
19 constrain prices -- you will see this talked
20 about in other points during the day as
21 leveraging market power.

22 We also looked at these avoidable
23 hospitalizations. A half minute on this
24 slide you will see a number of others that

1 look similar in the technical report.

2 The top of the arrow is the highest
3 price we observed once we cut off the tail.
4 So we look at the 95 percentile of prices
5 paid for the same DRG across all hospitals
6 and across all payers with the six large
7 insurance carriers in Massachusetts.

8 The low price, the bottom of that
9 arrow was the lowest price at the 5th
10 percentile.

11 Again, we cut off the tail so the
12 distribution we observed is actually larger
13 than this. And the price you see indicated
14 there is the average price.

15 So you see the variation here that
16 we are looking at. The variation for the
17 same DRG is 2 to 1 -- an enormous
18 difference. You see the same thing for
19 outpatient services and even more variation
20 in spending in outpatient services both in
21 hospital outpatient settings and in
22 free-standing clinic settings.

23 The same variation in physician and
24 professional services -- the lowest price

1 paid is -- we should reverse that, the
2 highest price paid is orders of magnitude
3 greater than the lowest price paid for the
4 same service.

5 And, secondly, we look at
6 readmissions. As I said, Massachusetts has
7 looked at this issue of readmissions before
8 and I think two things are important to take
9 away from this.

10 First of all, the rate of
11 readmission, all causes readmission within
12 30 days is relatively high and it, in fact,
13 adds almost \$50.00 to expenses per member
14 year in Massachusetts simply the costs of a
15 readmission within 30 days.

16 63 percent of readmissions are to
17 teaching hospitals in Massachusetts.

18 What is different about what we
19 have done in this study is to look then at
20 whether we could find a physician visit
21 within 30 days of discharge and what
22 difference that made and we found that, in
23 fact, it made a difference. It is all
24 cause. It is not adjusted for risk and that

1 suggests to me that if we did adjust for
2 risk, we would find even higher disparity
3 that we would find.

4 73 percent of index admissions that
5 is that first admission we could find when
6 it was followed by a physician visit
7 resulted in no readmission.

8 In teaching hospitals we found that
9 there was a lower probability of a physician
10 visit within 30 days and a higher
11 probability of readmission.

12 To the extent that there is
13 sufficient is primary care or follow-up care
14 following a hospitalization, it appears that
15 there is a substantial opportunity to reduce
16 costs.

17 PROFESSOR STANLEY WALLACK: Thank
18 you.

19 Let me start asking some questions.
20 You all spent a good amount of time doing
21 the study over the last year and there was a
22 lot of work to do and thank you for getting
23 it done.

24 But looking back at it now, I

1 guess, the first question I ask each of you
2 and maybe we will start with Cindy, what was
3 the most surprising finding on your part of
4 the study and, secondly, I guess, what would
5 you want to know to validate it?

6 I mean so what were you surprised
7 with, Cindy?

8 MS. CINDY PARKS THOMAS: Well,
9 first of all, I was surprised that national
10 data don't exist beyond 2004 to compare any
11 state to the nation beyond which created
12 greater challenges for us to understand
13 where Massachusetts is in context but beyond
14 that I think we all knew going into this the
15 strong presence of an academic center driven
16 system, however, the scale at which it was
17 -- it dominates was a pretty big surprise to
18 me.

19 The second thing is this issue of
20 outpatient services moving into the
21 outpatient care area, changing the footprint
22 of outpatient care being delivered by
23 hospitals and which hospitals is I think
24 pretty important and would really warrant

1 more -- I think warrants future
2 investigation.

3 PROFESSOR STANLEY WALLACK:
4 Dianna?

5 MS. DIANNA WELCH: I guess I will
6 start with what I think warrants some more
7 investigation which would lead to the
8 surprising part but really this issue that I
9 addressed last of the variability between
10 the rate increases I think it would have
11 been -- it would be great to study that
12 further in the future to get more
13 information about how wide the variability
14 is.

15 We really only have the ability to
16 look at averages in our study and so I think
17 it would be interesting to look at that I
18 guess because of some of the surprising
19 premiums trends that I was a little
20 surprised that we didn't see trends higher
21 or at greater disparity than what we found
22 between the market segments.

23 PROFESSOR STANLEY WALLACK: Thank
24 you.

1 MS. DEBORAH CHOLLET: I think the
2 surprising thing and I agree with Dianna
3 also I think the area that more
4 investigation is warranted is in the
5 dominance of price in driving overall
6 expenditure growth especially for inpatient
7 and physician professional services.

8 And then the role of price
9 variation in that process of expenditure
10 growth -- the amount of price variation was
11 astonishing frankly but not surprising given
12 how prices are set, but that being said,
13 when there is that much opportunity to find
14 a lower cost provider, one has to wonder
15 what systems might be put in place to help
16 both consumers and employers find lower cost
17 providers.

18 They may be paying relatively low
19 deductibles but they are also paying
20 co-insurance and the lack of opportunity to
21 find a lower cost provider and understand
22 whether there may be potential quality is
23 difference is, I think, is a key in
24 controlling costs.

1 PROFESSOR STANLEY WALLACK: Thank
2 you. Good answers.

3 For those of you who haven't read
4 the stack as someone described of the
5 reports, there is a lot in there and I think
6 I appreciate you coming up with sort of the
7 highlights and then these couple of points.

8 But Cindy an important finding that
9 you didn't highlight here -- it was in the
10 contents paper so all of you should look at
11 it, again, Part 1, was that although you
12 adjusted and showed we were 27 percent
13 higher when you did the adjustments for
14 revenue and wage, you came to Massachusetts
15 is 15 percent higher. There is also a
16 really interesting graph, diagram in the
17 report that shows while Massachusetts
18 spends, you know, at a high level, 13
19 percent, when you compare this to states at
20 similar income levels, we are sort of in the
21 middle and you didn't bring that up but I
22 think it is, again, this context of what is
23 good, how do you do that and what do you
24 have to say about it?

1 MS. CINDY PARKS THOMAS: Yes,
2 that is an interesting point.

3 We are kind of in the middle but I
4 would say that health care costs are a
5 challenge for all states and we can find, we
6 are not unique in that way.

7 We need to address these
8 challenges, but there are states that have
9 an efficient system that we didn't talk much
10 about yet and we will over the next few days
11 that have found a way to have a lower
12 portion of their state product going to
13 health costs -- they have found more
14 efficient ways to provide care.

15 There are opportunities and other
16 states and systems have found that.

17 PROFESSOR STANLEY WALLACK: I
18 want to go back, Dianna, to what you
19 discussed which is sort of the volatility
20 issue, because I think that the actuarial
21 kinds of simulations, aspects that you made
22 was interesting.

23 But I want to ask you a question
24 given also your experience at Blue Cross and

1 being in the trenches there and not being a
2 consulting actuary about how those really do
3 translate -- how those variations that you
4 have pointed translate into actual premiums
5 that firms are asked to pay.

6 I was talking to a small business
7 owner in Fall River last Friday and he said
8 he was happy he only got a 15 percent
9 increase, okay?

10 But he was also surprised because
11 he said that the two oldest workers or the
12 two people over 60, he let go, they left his
13 insurance policy. So he thought his rates,
14 in fact, should be adjusted down and when I
15 looked at the volatility, and I know you
16 always see the bad stories, the ones that
17 got 15, 20, 25 percent but we would expect
18 to see in the analysis some people having
19 decreases or very low increases.

20 So I wonder if you could sort of
21 explain. I mean I said I was an economist
22 but I was going to meet with an actuary on
23 Monday -- I had asked her to sort of explain
24 to me do insurance companies when they look

1 at those demographics and demographics which
2 should really drive down the premiums, how
3 do they deal with that when they set the
4 rates?

5 MS. DIANNA WELCH: Well, if you
6 are talking specific to the small employer
7 market there are ratings limitations in the
8 market here that constrain what the insurers
9 can do.

10 It also requires that every small
11 employer of similar characteristics has to
12 be treated similarly. So the insurers are
13 not looking employer group by employer group
14 and setting the premiums, they have to use
15 consistent factors in setting those
16 premiums.

17 So every small employer who drops,
18 you know, loses a 65 year old worker and
19 picks up a young worker should see the
20 benefit of that in their rate. Of course,
21 in any given rate renewal there is so many
22 moving pieces. There could be changes made
23 to the benefit plan design that they had.
24 There could be changes made to the size of

1 the group that effect the increase. There
2 could be changes in age. You know, there
3 are many things that effect it. The
4 carriers could be shifting their pricing of
5 how they evaluate a different area
6 adjustments.

7 So in anyone given renewal for any
8 given employer there are many, many
9 different factors that play into the final
10 premium all of which ultimately have to be
11 within the rating limitations of the state.

12 PROFESSOR STANLEY WALLACK: So
13 you think if we actually did the survey with
14 all firms we would find some decreases
15 maybe?

16 MS. DIANNA WELCH: I would think
17 that there should be a wide range.

18 There will be some large increases
19 and there should also be firms out there
20 that would receive decreases if they have
21 gotten younger since the last renewal.

22 PROFESSOR STANLEY WALLACK:
23 Deborah, the overall growth expenditures
24 that you showed, hospital outpatient

1 facilities were really increasing, but you
2 also showed -- you showed in your graph that
3 free-standing facilities -- you also showed
4 those but what you didn't go into in this
5 discussion, what you did go into in your
6 larger paper was we have seen a change. We
7 sort of have free-standing facilities
8 actually decreasing overall and sort of the
9 outpatient facilities, a portion of care
10 there actually going up.

11 Do you have any sense about what is
12 going on from digging deeper into the
13 analysis of the kinds of services or why we
14 might be seeing that -- the shift between
15 free standing and outpatient hospital
16 facilities?

17 MS. DEBORAH CHOLLET: No, the
18 data don't really give any indication of why
19 we might be seeing it but there does seem to
20 be a transition away from the use of
21 free-standing facilities to hospital
22 outpatient departments.

23 The services that are being offered
24 in hospital outpatient departments aren't

1 necessarily much more expensive than were in
2 free-standing facilities -- they are
3 somewhat more expensive and as I mentioned
4 before the variation in both free-standing
5 facilities and outpatient facilities is very
6 large.

7 What is driving that transition
8 from one to the other out of free-standing
9 facilities into Outpatient Department isn't
10 apparent.

11 PROFESSOR STANLEY WALLACK: I am
12 going to take one of the questions from the
13 group here and it is a question dealing with
14 teaching facilities -- both I think on the
15 outpatient and the inpatient side, and why
16 is spending going through the high teaching
17 hospitals, who or what is steering that
18 activity to teaching facilities?

19 You described in your analysis that
20 you were seeing, one of the reasons and I
21 think in some of the responses from the
22 insurers, they said if you look at the price
23 increase, you know, maybe 25 to 30 percent
24 of it is as a result of these shifts that

1 are occurring between providers.

2 So there is more care in your
3 analysis outpatient and your analysis of
4 inpatient in the report -- more care going
5 to teaching facilities.

6 Do you have any idea? The question
7 was who or what is steering the activity to
8 teaching and academic hospitals?

9 MS. DEBORAH CHOLLET: I think the
10 answer is that no one is really staring it.
11 I think what you are looking at is
12 non-exclusive networks where the teaching
13 facilities are included in the network as
14 well as the non-teaching facilities and that
15 leaves it up to the patient to make the
16 decision and maybe the patient's physician
17 obviously to make a decision about whether
18 the patient goes for inpatient care and with
19 respect to outpatient care, it is likely to
20 be reputation of the facility -- whether the
21 reputation is, you know, warranted or not
22 warranted for the particular services that
23 the patient is seeking.

24 PROFESSOR STANLEY WALLACK: One

1 of the things we didn't have time to do --
2 yes, that is right -- one of the things we
3 didn't have time to do was to really look at
4 the effect on these growing networks between
5 the hospital and the physicians and I think
6 maybe the person asking the question was
7 asking about what hospitals are being used
8 as these hospital physician networks
9 actually get larger.

10 This is a question just brought to
11 be which I will read. It is around payment
12 reform and one of the issues -- I will
13 paraphrase the question -- when we look to
14 payment reform and we looked at some global
15 payment of capitalization what we are trying
16 to get at is changes in utilization -- move
17 care to less expensive settings but given
18 your analysis today of price being the major
19 driver is your focus on the -- is the focus
20 on fee for service misplaced or the focus on
21 global capitation misplaced?

22 Interesting question, thank you.

23 MS. DEBORAH CHOLLET: I don't
24 think the focus on greater bundling of

1 services is necessarily misplaced but I
2 think what has to occur or what would be
3 beneficial if it occurred would be a greater
4 rationalization of the system.

5 So even if you have a bundle of
6 payment, you have to establish a level of
7 payment and that level of payment needs to
8 be rationalized and it needs to be premised
9 more clearly on the value of the service and
10 the efficiency of the location of the
11 service.

12 I think the idea of bundling
13 payment is that that is done internal to a
14 decision process by a provider group -- and
15 not done externally via regulation.

16 But it is appears that even when
17 payments are bundled currently -- that is
18 when we are seeing capitated payments -- the
19 same apparent irrationality of payment
20 persists.

21 We saw no evidence that a capitated
22 payment amount was substantially less than
23 an uncapitated fee for service payment
24 amount.

1 So, overall, the rationality of the
2 system needs to be improved regardless of
3 whether the services are bundled or paid fee
4 for service.

5 PROFESSOR STANLEY WALLACK: And
6 also you had mentioned in the contents
7 paper, one of the things that was mentioned
8 was that when we saw the growth -- of
9 course, we had regulation for prices in the
10 '80s, it turned a curve in '91 -- once you
11 saw managed care come on people thought managed
12 care could bring down prices and bring down
13 premiums and they did and I think there was
14 excess hospital beds and I think Cindy was
15 showing some of the shifts that went on as
16 small hospitals closed, we had more teaching
17 hospitals.

18 We have changed the balance, I
19 think, over the last ten years between
20 providers and payers and I think one of the
21 questions we are pursuing over the next
22 couple of days is who has leverage in these
23 negotiations and I think that that is an
24 issue as well.

1 I think whoever is asking the
2 question is probably thinking about how has
3 the marketplace changed here and we have to
4 have a very comprehensive approach.

5 I have a question -- I am going to
6 turn to a question that I have for Dianna.
7 I will give you one.

8 One of the questions that I found
9 interesting and I found most surprising
10 perhaps about your analysis other than the
11 volatility question that somebody asked me
12 about was actually the very small difference
13 in the administrative -- the loss ratios or
14 the administrative costs between the small
15 groups and the medium-sized groups and the
16 large groups wasn't very large and I have
17 always thought from reading national papers
18 that the small groups have these very large
19 brokerage commissions and, therefore, the
20 administrative costs are much higher and
21 your results don't show that.

22 I wonder if you could explain that.

23 MS. DIANNA WELCH: They don't
24 show that there are significantly greater

1 commissions in the small group market.

2 That may be something that is a
3 little unique to Massachusetts. If I think
4 if we were to look outside of Massachusetts,
5 you might see some higher commissions being
6 paid in the small group market and in
7 particular in the individual markets outside
8 of Massachusetts typically have much higher
9 commissions whereas here the individuals are
10 now merged within the small groups and we do
11 see lower commissions here.

12 The other things that we have seen
13 that was highlighted is the narrowing of
14 that gap in non-medical costs between the
15 small employers and the large employers over
16 the study period so when we look back a
17 couple of years, that gap was wider and
18 health plans have reduced that gap just
19 recently here in the last couple of year
20 years.

21 PROFESSOR STANLEY WALLACK:

22 Cindy, I have a question to you and we will
23 go back to some questions from the audience.

24 Cindy, what you reported on the

1 context paper, there seems to be little
2 distinction between HMOs and PPOs and I am
3 wondering if -- that was another surprising
4 finding that they are all paying fee for
5 service. So if we did a PMPM -- we just
6 pressed per member per month -- what do you
7 think we would find?

8 We have all heard about HMOs being
9 more efficient in terms of driving down
10 costs and utilization -- do you have any
11 sense with that.

12 MS. CINDY PARKS THOMAS: Since we
13 are dominated by large networks, I would
14 imagine there may not be much difference
15 between the HMO or the per member per month
16 cost.

17 PROFESSOR STANLEY WALLACK: Let
18 me ask one question -- I have a final
19 question -- let me ask -- I have a couple of
20 minutes and I am done? Okay.

21 So I have a question here and if
22 anyone wants to take it on, I won't aim it
23 at Deborah, but if anyone wants to take it
24 on -- but the question is please discuss the

1 impact on increasing private insurance costs
2 and provider costs for hospitals with high
3 Medicaid and Medicare patient mixes and are
4 underfunded public payment rates.

5 We could leave it for another
6 panel.

7 Did any you of want to take that
8 on?

9 MS. DEBORAH CHOLLET: I have not
10 looked at that issue in Massachusetts but I
11 have looked at it in other states and I
12 would hazard to guess that the pattern is
13 consistent here.

14 There is cost shifting where the
15 market allows cost shifting to occur.

16 So when we look, for example, at
17 competitive markets where there are a number
18 of hospitals, a number of physicians that
19 are competing, we don't see any relationship
20 between the rate at which the public payer
21 is paying and the rate that the private
22 payers are paying. You don't see that cost
23 shift. You don't see an increase in prices
24 associated with the failure of the public

1 sector to increase prices overtime.

2 But in markets where providers have
3 market power, where they have leverage, you
4 will see an increase in private payer rates
5 associated with that.

6 So, in general, if I as an
7 economist assume a revenue maximizing
8 institution or a revenue maximizing provider
9 and there is no constraints on maximizing
10 revenues, that is pretty much what happens.

11 So the cost shifting story is
12 somewhat complicated. It is driven by
13 competition and the kind of hydraulic
14 approaches -- whatever Medicare and Medicaid
15 don't pay private payers pay simply doesn't
16 pan out.

17 PROFESSOR STANLEY WALLACK:

18 Again, as we study, as we learn more by
19 doing Medicare and Medicaid, I think we will
20 learn more what is certainly going on in
21 this state and we also have the power of
22 that provider, the private payer wanting to
23 know what that market looks like. We also
24 have the numbers.

1 If you are a private insurer you
2 are not sending a lot of people to this
3 facility -- that may have an effect on
4 negotiations as well -- what the importance
5 will be for the private payer to pay the
6 higher rate.

7 So let me ask my last question. I
8 could go on. Believe me, there is a lot of
9 stuff here.

10 Let me ask another question and it
11 has to do with this outpatient issue
12 because I think -- outpatient hospital
13 facility issues -- so we recognize in this
14 state and it is certainly documented that we
15 have seen this tremendous growth in
16 outpatient hospital facilities and it is one
17 that is growing fastest relative to its
18 baseline that Deborah showed us. Now that
19 growth can be looked at positively if we are
20 taking expensive patients out of the
21 inpatient setting and putting them into a
22 less expensive setting that is positive.

23 If, however, we are seeing the
24 outpatient facilities grow and care is

1 moving from the less expense facility
2 physician's office, we are paying for the
3 higher facility costs for these outpatients.

4 So I would like each of you from
5 your experience in other states or from your
6 experience in sort of just generally in
7 health services to tell me whether you have
8 any sense of what is going on here -- is it
9 a good thing or a bad thing that we are
10 seeing this tremendous amount of growth and
11 is it something that we should sort of --
12 people should be thinking about in this
13 state with regard to DON -- is that what it
14 is -- with regard to outpatient facilities.

15 Cindy, do you want to start with
16 that?

17 MS. CINDY PARKS THOMAS: Yes, I
18 think that -- I don't believe that the
19 flattening or decreasing growth in hospital
20 admissions is really commensurate with the
21 increase in outpatient services.

22 I don't think many of us believe
23 this is true. We are substituting
24 outpatient for inpatient -- that may be

1 happening to some extent but I think as
2 outpatient facilities expand particularly in
3 a teaching hospital, it is an attractive
4 setting for physicians to provide care.

5 I know, for instance, physicians
6 providing cancer care are now providing them
7 in hospital outpatient settings to a greater
8 rate than with the change in reimbursement
9 particularly by Medicare -- I think that
10 hospitals as they are interested in
11 expanding these various areas, I think they
12 are quite attracted to physicians to provide
13 care in those settings without having to
14 overpay.

15 PROFESSOR STANLEY WALLACK: That
16 is just conjecture?

17 MS. CINDY PARKS THOMAS: Yes.

18 PROFESSOR STANLEY WALLACK: A lot
19 of outpatient cases with these new cancer
20 infusion drugs -- Dianna?

21 MS. DIANNA WELCH: I don't have
22 anything to add on that.

23 PROFESSOR STANLEY WALLACK: This
24 driving costs that you have seen in any

1 other states? Is that unusual?

2 Cindy showed we are very high and
3 is that something that we are seeing
4 happening?

5 MS. DIANNA WELCH: I wouldn't say
6 it is unusual to see high trends and in
7 particular high trends in the outpatient.
8 Anything beyond that is --

9 PROFESSOR STANLEY WALLACK:
10 Thanks. Deborah --

11 MS. DEBORAH CHOLLET: I think
12 there are two ways to look at this.

13 No. 1, I think avoiding a hospital
14 inpatient admission is a good thing on the
15 whole simply because of the dangers of an
16 inpatient admission -- that the patient does
17 not control that environment and we know
18 from substantial research that there is a
19 risk of injury and infection in an inpatient
20 environment that might not exist in an
21 outpatient environment.

22 However, it is hard to control
23 costs in an outpatient environment for the
24 same reasons that a regulator is not much in

1 control of that situation. Providers and
2 patients are in control of that situation.

3 And I think that that is the reason
4 that we are seeing both an increase in price
5 and the increase in the volume of services
6 driving costs in that sector.

7 It is very hard for a regulator to
8 get their arms around an outpatient
9 environment. We see that even in states,
10 for example, in Maryland and West Virginia
11 that regulate inpatient hospital rates.

12 They are also seeing fast growth in
13 outpatient expenditures because they haven't
14 regulated them in the same way.

15 PROFESSOR STANLEY WALLACK: It is
16 an opportunity to talk about global
17 capitation to rationalize that system.

18 We have a very hard time with the
19 outpatient side relative to the inpatient
20 side.

21 I am reminded of one of the
22 readings I gave my students in class -- as a
23 Professor, I give a lot of reading to keep
24 them busy, but one of the readings was

1 The Hospital is a Doctor's Workshop but is a
2 an older article. Why is it something
3 from -- I won't say the year -- but probably
4 something from the early '80s or late '70s,
5 it sounds to me one of the answers that
6 Cindy is giving us -- that a lot of the ways
7 the hospital outpatient facility has become
8 in some ways a really good place for a
9 physician to do practicing for a variety of
10 reasons that enables them whether it is
11 imaging or cancer infusion drugs.

12 It is important thing for us to
13 learn a lot about. Because it may be higher
14 quality as Deborah said, but it is really
15 where the costs are being driven.

16 So I think as you get your agenda
17 ready, David, for going forward, that is
18 certainly an area that I think you want to
19 concentrate on.

20 So thank you to the panel and I
21 hope we all learned something.

22 (Applause from the Audience.)

23 COMMISSIONER DAVID MORALES:

24 Thank you, Professor Wallack.

1 Two very quick things -- one, I
2 would like to invite Chairman Jeffrey
3 Sanchez, Chairman of the Joint Committee of
4 Public Health and the House of
5 Representatives to offer brief remarks and
6 then we will take a short break.

7 (Applause from the Audience.)

8
9 REPRESENTATIVE JEFFREY SANCHEZ:

10 Good morning, thank you so much,
11 Commissioner Morales and members of the
12 panel, thank you for your insight.

13 Again, I want to first of all thank
14 you for inviting me to make a brief
15 statement before the panel.

16 All of us know and we know
17 that our system is fundamentally flawed. We
18 have to try to figure out how we go about
19 despite our success how we make our health
20 care system responsible accountable and make
21 sure that the system are working for
22 everyone.

23 Not only that we have but we have
24 to do it in an environment that brings down

1 our costs and improves quality.

2 We have been able to do so much
3 through Chapter 305 that included proposals
4 to increase transparency and health care
5 spending and improve our public reporting of
6 patient outcomes and more demanding of
7 patient safety protocols.

8 305 also established several
9 collaborative efforts to realign our health
10 care delivery models to fit a more modern
11 patient centered approach to care.

12 Now our task is to build upon
13 Chapter 305.

14 In my time as the House Chairman of
15 Joint Committee on Public Health, I have met
16 with many of the stakeholders who will
17 address this panel over the coming days and
18 they all have a unique and informed
19 perspective on the contributing factors to
20 the current crisis facing the Commonwealth.

21 What we do not have is a consensus
22 opinion on where the problems lie and how to
23 address those problems and that job of
24 building that consensus falls to us.

1 Our task as public officials is to
2 weave individual perspectives in a coherent
3 public policy that will provide a positive
4 lasting benefit for all of the people of the
5 Commonwealth and, yes, businesses as well.

6 And to achieve this lasting and
7 comprehensive solution to the problems
8 plaguing our system, I would suggest that
9 this panel and those who appear before it
10 expand inquiries beyond the traditional
11 questions of health insurance and payment
12 reform while I enjoin the dialog and
13 discussion on variables and market failures
14 and all of those great terms that the
15 average citizen, you know, tries to
16 understand and, you know, especially when
17 they are hearing them from us -- we have to
18 try to make sure that, again, we look at the
19 lack of emphasis on preventative health
20 policies.

21 For far too long we focused on the
22 financial side of getting care to the sick
23 to the solution of where we should exert our
24 efforts to prevent sickness and disease.

1 Asthma, heart disease, diabetes and
2 other chronic illnesses are preventable and
3 treatable and our health policies must be
4 aimed at curbing the effects these
5 conditions have on the public health and the
6 bottom line.

7 Less than 5 percent of all of our
8 health expenditures are spent on prevention
9 and wellness efforts -- yet for every dollar
10 spent on initiatives to increase physical
11 activity, improved nutrition and prevent
12 smoking, a total of \$5.60 can be saved in
13 health care costs.

14 Preventive health policies and new
15 efforts to educate citizens on the
16 importance of making healthy choices must be
17 an integral part of any health care savings
18 initiate.

19 Another aspect of public health
20 policy that would be crucial in any
21 successful effort to reduce spending is the
22 ongoing effort to eliminate disparity and
23 access to care for vulnerable populations
24 especially those who are in underserved

1 areas of the Commonwealth.

2 Our health care reform is an empty
3 promise if we do not address the barriers of
4 care and disparities of access that still
5 remain despite our success in providing near
6 universal health insurance coverage.

7 And we cannot ignore the economic
8 fact between 2003 and 2006, 30.6 of direct
9 care expenditures for African Americans and
10 Asians and Hispanics were excess costs due
11 to health inequalities. Examining the
12 matters that have been brought before the
13 Joint Committee on Public Health there are
14 other contributing factors to our health
15 care financing crisis that we should also be
16 including in the discussion on cost control
17 and health care reform.

18 For instance, the continuing
19 evolution of education and training
20 standards for health professionals that
21 support our physician community should lead
22 us to examine how we better use each member
23 of the health care team to maximize the
24 effectiveness of patient care and foster

1 better patient outcomes.

2 Reducing health care spending will
3 require us to make sure that public policy
4 utilizes all of our health professionals
5 education and training to provide care to
6 patients in a way that bought maximizes
7 their skill sets and reduces health costs to
8 patients.

9 Professional services such as
10 advance practice nurses, clinical
11 technicians, community health workers and
12 non-traditional care providers must be a
13 part of this dialogue to ensure that
14 patients have increased access to well
15 trained and qualified providers who are able
16 to -- who are able to with their educational
17 standards and scope of practice without
18 outdated or arbitrary restrictions on their
19 practice.

20 We need to ensure the smooth
21 integration of health records and new
22 technologies and do so in a way that extends
23 the benefits to all providers and we need to
24 also coordinate patient care to the spectrum

1 of health care providers to reduce
2 duplication of treatment and improved
3 outcomes and prevent medical errors.

4 Also, in the committee, we have
5 also looked at general administrative and
6 oversight capabilities to identify
7 structural inefficiencies in the delivery of
8 healthcare to try and look at wasteful
9 spending.

10 I know that I share the view of my
11 legislative colleagues that the road ahead
12 of us will not be easy but that we must act
13 now to stem the tide of unmanageable health
14 spending increases for Massachusetts
15 families and businesses.

16 I look forward to working with
17 members of the panel and forging ahead with
18 the next steps.

19 I have taken enough time. I thank
20 you so much, Commissioner and I thank you
21 members of the Panel.

22 (Applause from the Audience.)

23 COMMISSIONER DAVID MORALES: We
24 are going to take a very brief three-minute

1 break and we will be back here at 11:25.

2
3 (Short Recess.)
4

5 COMMISSIONER DAVID MORALES:

6 Thank you.

7 I would like to ask Commissioner
8 Murphy to approach the podium for the next
9 presentation.

10 COMMISSIONER JOSEPH MURPHY:

11 Thank you, Commissioner.

12 I am Joe Murphy. I am the
13 Commissioner of Insurance and I am joined
14 here today by Kevin Beagan who is our Deputy
15 Commissioner for our Health Care Access
16 Bureau.

17 We appreciate the opportunity to
18 join you here today.

19 Today I would like to give an
20 overview of the small group market and also
21 talk about the review that we have
22 undertaken of recent small group rate
23 increases.

24 At the most basic level health

1 plans provide or arrange payment to
2 providers for covered services to insure
3 individuals for employer groups. The
4 delivery of health care and the
5 administration of health insurance coverage
6 has been become more complicated over time
7 because doctors, hospitals and other
8 providers have access to effective
9 techniques and services that could not be
10 imagined 20 years ago.

11 We as consumers of health care
12 expect our health plans to pay for these
13 services when we need them.

14 The American market is more complex
15 than other systems because of the level of
16 choice. Large and small employers,
17 employees and individuals can chose from a
18 variety of health plans offering different
19 benefits, cost sharing and provider systems.
20 The greater the number of choices the more
21 complicated the system and its
22 administration.

23 As the complexity increases, higher
24 costs and inefficiencies follow.

1 Beyond the differing level of
2 health care benefits, Massachusetts
3 residents expect the right to go to their
4 doctors and hospitals when they need them.
5 Unlike many other states the major
6 Massachusetts health plans have created
7 networks that include almost all of the same
8 providers whether they are high cost or low
9 cost.

10 Massachusetts residents have
11 intimated in comments to the Division and
12 complaints to health plans that a plan is
13 inadequate if it does not have access to all
14 of the providers that people want when they
15 need them.

16 Over the past half century the
17 government, private businesses, employers,
18 consumer advocates and health plans have
19 tinkered with the levels of choices as to
20 networks have tied to implement point of
21 service systems and tiered arrangements and
22 health savings accounts and have utilized
23 managed care tools in consumer education in
24 an attempt to impact choice and provide

1 incentives for covered persons to get the
2 appropriate level of care.

3 Health care costs and health
4 premiums are continuing to rise at alarming
5 levels despite the actions described above.

6 According to a report issued by
7 Oliver Wyman for the Division between 2002
8 and 2006 the total costs for medical
9 services per insured member per month
10 increased by 55 percent for an average
11 increase of 11.6 percent per year.

12 Some claim that costs have
13 increased at higher rate for small employers
14 offer the past few years. As employers and
15 individuals are forced to pay high prices,
16 these increases threatened to strangle
17 businesses efforts to recover from the most
18 recent recession.

19 In August of 2009, Governor Deval
20 Patrick charged the Secretaries of Housing
21 and Economic Development, Health and Human
22 Services and Administration and Finance to
23 explore and evaluate all reasonable options
24 to address the rising cost of health

1 coverage impacting Massachusetts small
2 businesses.

3 The Secretaries detailed ongoing
4 efforts being conducted through their own
5 agencies and through the health care quality
6 and cost counsel to restructure the method
7 of paying providers and to simplify the
8 administration of health care services as
9 well as additional items that needed
10 immediate review.

11 On October 20th, 2009, among other
12 actions, Governor Patrick directed the
13 Division of Insurance to schedule
14 informational hearings to examine health
15 care premium increases concentrating on
16 small group premium changes and actions that
17 companies are taking to address costs.

18 During this time the Division
19 invited each small group health carrier as
20 well as hospitals and providers groups to
21 explain their own systems and the reasons
22 that the costs were increasing.

23 The Division held introductory
24 hearings in the first week of November in

1 Lowell, Springfield, Boston, Bridgewater and
2 Worcester to listen to public comment on the
3 questions upon which it should concentrate.

4 Over the next seven weeks the
5 Division instructed the ten health carriers
6 participating in Massachusetts small group
7 health insurance market to respond to a
8 series of questions regarding the following
9 topics.

10 Week One -- company cost
11 containment initiatives. Week Two, health
12 benefit design, marketing and
13 administration. Week Three, consumer
14 services, financial systems and regulatory
15 affairs. Week Four, general management
16 expenses and claims payment systems. Week
17 Five, provider contracting and network
18 management. Week Six, utilization
19 management and claims payment trends. Week
20 Seven, premiums development for whole plan
21 and smaller groups.

22 In addition to the health plan
23 hearings, the Division invited each of the
24 state's hospitals and health care provider

1 trade associations to attend hearings
2 between January 7th and January 12th to
3 provide testimony or submit materials in
4 written form.

5 Over the past two weeks we
6 conducted a second set of hearings across
7 the state including stops in Boston,
8 Fitchburg, Framingham, Hyannis, Lawrence and
9 Pittsfield.

10 We have collected reams of
11 information through this hearing process and
12 also through our confidential examination
13 authority.

14 The Division was directed by
15 Governor Patrick to examine information
16 presented in these hearings that propose
17 changes that may be implemented in statute,
18 benefit design or administrative practices
19 to mitigate the substantial annual increases
20 that have impacted the small group market.

21 On February 10th the Governor
22 announced the jobs package that includes
23 both regulatory and legislative efforts to
24 assist small businesses with their health

1 insurance costs.

2 On the regulatory front the
3 Governor directed the Division of Insurance
4 to issue an emergency regulation requiring
5 carriers to file their proposed small group
6 rates at least 30 days in advance starting
7 with those with 4/1/2010 effective dates.

8 Carriers are now also required to
9 file substantial documentation to support
10 their proposed rates.

11 DOI is reviewing this information
12 and will determine if the rates should be
13 disapproved. The legislative components of
14 this package include soft caps on insurer
15 and provider rates for a period of two years
16 and legislation that will provide for more
17 affordable options in the marketplace.

18 According to reports developed by
19 the Division of Insurance as of December
20 31st, 2009, a total of 815,931 persons were
21 covered under small group health insurance
22 plans including 72,513 individuals and
23 743,418 covered through small employers.

24 The Massachusetts market for small

1 group health insurance is dominated by
2 coverage offered by the state's health
3 maintenance organizations which account for
4 87 percent of this coverage.

5 The remaining coverage is
6 predominantly with Blue Cross and Blue
7 Shield's non-HMO plan, the Assurant Health
8 Insurance Companies and other insurance
9 companies who are no longer offering
10 coverage.

11 Among the HMO plans, the statewide
12 plans offered by Blue Cross and Blue Shield,
13 HMO Blue, Harvard Pilgrim Health Care and
14 Tufts Associated Health Maintenance
15 Organization account for over 85 percent of
16 all HMO membership.

17 Unlike the markets in many other
18 states, the Massachusetts market is
19 dominated by Massachusetts centered
20 nonprofit health maintenance organizations.
21 The four largest plans grew from regional
22 health plans to statewide plans that operate
23 in limited other jurisdictions.

24 The large national health plans,

1 United Health Care of New England and Aetna
2 which have substantial presence in other
3 states account for less than 1 percent of
4 the Massachusetts small group health market.
5 The four largest health maintenance
6 organizations each offer robust provider
7 networks that include the vast majority of
8 hospitals, primary care providers and
9 specialty physicians that are available
10 throughout Massachusetts.

11 Although there are minor
12 differences in the service delivery systems
13 of the providers under contract in each
14 plan, in general the networks each offer
15 approximately the same access to hospitals
16 and physicians throughout the state.

17 These health plans do not compete
18 at this time based on access to providers
19 but instead strive to have network that are
20 similar to their competitors so they will
21 not lose any competitive position to the
22 others.

23 In the one year period between July
24 1st, 2008 and June 30th, 2009 the largest

1 seven health maintenance organizations
2 collected 13.8 billion dollars in revenue
3 from premiums and fees generated from
4 serving self-funded accounts.

5 Revenue generated from small group
6 health plans accounted for 3.2 billion
7 dollars during this period. During the
8 above noted one-year period large group
9 premium revenue accounted for almost half of
10 all revenue generated by the health plans.

11 Small group premium was smaller but
12 still accounted for over 23 percent of total
13 revenue.

14 If government revenue were
15 excluded, small group premium revenue would
16 account for over 30 percent of all revenue
17 generated by the largest seven HMOs.

18 As noted previously, the companies
19 in the Massachusetts market compete
20 aggressively to maintain and grow their
21 shares of the market.

22 In the large group market carriers
23 experience rate based on each large
24 employers prior and projected medical

1 expenses compared to other large groups.

2 In the small group market carriers
3 are required to base rates based on the
4 prior and projected medical expenses of the
5 overall small group market with adjustments
6 based on the age, industry, participation
7 rate and location of the group.

8 In response to claims that small
9 group rates were increasing more rapidly
10 than those of the large group market, the
11 division looked more closely at the overall
12 trends in April of 2009.

13 At that time certain companies did
14 increase rates more for small group than for
15 large groups.

16 For example, Blue Cross and Blue
17 Shield of Massachusetts raised the base
18 rates for its two most popular small group
19 plans by over 14 percent while keeping rates
20 for its large group plans to under 10
21 percent.

22 We hope to issue a report on our
23 findings as a result of all of these
24 hearings within the next month, however, I

1 would like to share some preliminary
2 findings from our report.

3 The top HMOs, Blue Cross and Blue
4 Shield, Harvard Pilgrim and Tufts Health
5 Plan cover 87 percent of those enrolled in
6 HMOs. Each is a local nonprofit contracting
7 with over 65 hospitals, 4,000 primary care
8 doctors and 16,000 specialists. On average,
9 85 to 89 percent of each premium dollar is
10 spend on health care payments to hospitals
11 and other health practitioners. The
12 remaining amounts are devoted to
13 administrative expenses or contributions to
14 surplus.

15 It is becoming more complex to
16 administer plans due to three main issues --
17 one being provider networks.

18 Network hospital and non-hospital
19 providers have increased reimbursement
20 demands to pay for technology, training and
21 capital expansions as well as to subsidize
22 underpayments from government and other
23 creditors.

24 Second, employer products --

1 employers have increased demands to reduce
2 benefit costs while maintaining the same
3 level of health benefits and are exploring a
4 wider array of cost sharing and tiered
5 network plans.

6 Third, regulatory constraints,
7 plans need to devote resources to design
8 health plans and rates and responding to
9 consumers, contract with providers, develop
10 utilization review and cost containment
11 programs and pay claims and report to
12 financial and regulatory agencies and
13 develop information technology systems to
14 keep up with this complexity.

15 Another finding was the increase in
16 complexity causes inefficiency and raises
17 costs to all.

18 Small group and large group
19 premiums are both growing but small group
20 premiums are growing at a faster rate.

21 Small group administrative costs
22 are higher than those of large employers
23 mostly because HMOs perform many more
24 enrollment functions for small employers and

1 need to spread certain account level costs
2 over a smaller pool of employees.

3 Small group utilization is higher
4 than utilization for large employers.
5 Individuals are allowed to jump into
6 coverage when they need it to pay for health
7 services and jump out after this treatment
8 is provided.

9 Large employers are much more
10 likely to employ health management or
11 wellness programs that address employees who
12 are at risk of developing chronic health
13 conditions.

14 The following options were raised
15 during the course of the hearings to help
16 carriers decrease the cost of coverages to
17 small employers. Again, these are options,
18 not necessarily recommendations and they
19 will be more fully discussed in our report
20 to be issued later this month.

21 Under the heading of creating more
22 affordable small group products, some of the
23 options we have heard or explored include
24 requiring the marketing of plans through all

1 distribution channels; the requiring the
2 offering of one product -- at least one
3 product -- that does not meet MCC levels,
4 requiring the offering of at least one
5 selected network product; permitting the
6 offer of coverage through group purchasing
7 cooperatives; permitting health plans that
8 exclude mandated benefits; permitting
9 carriers to offer at least one tiered
10 benefit product where doctors may move from
11 one benefit tier to another during the
12 contract period; requiring a plan whose
13 provider rates are capped. This is also
14 known as the affordable health plan
15 legislation.

16 We also heard a lot about making
17 adjustments to the small group rating rules
18 and under this heading some of the options
19 we are considering include allowing the
20 Commissioner to annually adjust rating rules
21 to eliminate duplicate or unwarranted costs;
22 eliminating age rate factors; capping the
23 application of rating factors to reduce
24 shock when group composition changes;

1 smoothing rate factors to reduce rate shock;
2 allowing carriers to offer wellness and
3 tobacco use adjustments outside the
4 permissible 2 to 1 band; requiring review of
5 changes in the benefit level rate adjustment
6 factor.

7 Under controlling small group
8 market utilization we heard the following
9 options. Create open enrollment period for
10 individuals. Require small employers to use
11 wellness or smoking cessation programs,
12 create a high risk pool for those
13 individuals with potentially expensive
14 costs, require that small group products
15 include higher incentives to use primary
16 care providers, require regular reviews of
17 existing mandated benefits and repeal
18 ineffective ones, institute a moratorium on
19 mandated benefits, increase the individual
20 mandate penalty and limit prorating of
21 penalties.

22 Under the topic of eliminating
23 anti-competitive forces we heard the
24 following options and they will, again, be

1 addressed in our report later this month.
2 Prohibiting non-competitive provisions from
3 being in contracts. Prohibit tie-in deals
4 in provider contract negotiations. Limit
5 the profits of insurance and pharmacy
6 companies.

7 Under improving claims handling we
8 heard about encouraging providers filing
9 claims on paper to use administrates to file
10 these claims electronically, requiring
11 carriers and providers to use electronic
12 means to process all claims materials and to
13 use electronic medical records to store
14 patient information.

15 We also heard about requiring
16 carriers to penalize providers who do not
17 file electronically or file inappropriate
18 claims.

19 Under the topic of increasing
20 transparency, the options we are considering
21 include requiring reporting of complaints
22 statistics, requiring reporting of detailed
23 administrative expenses on supplemental
24 financial statements, requiring a reporting

1 of all cost containment efforts.

2 Under standardizing the
3 authorization processes across HMOs, we
4 heard about requiring carriers and providers
5 to follow the same processes to authorize
6 requests for service. Require carriers and
7 providers to use the exact same medical
8 necessity criteria.

9 Under standardized billing and
10 coding processes across HMOs, we have looked
11 at limiting the look back period for
12 carriers to audit prior payments to
13 providers, requiring all product benefits
14 and cost sharing to be the same, requiring
15 carriers to collect all co-payments,
16 deductibles and other cost sharing.

17 Under the topic of standardizing
18 HMO administrative processes, we have heard
19 about further standardizing the
20 credentialing process across all plans.
21 Prohibiting carriers from transferring
22 mental health care to carve out
23 organizations, requiring all providers to
24 accept global payments at sometime in the

1 future, requiring plans to penalize
2 employers for filing retroactive changes to
3 enrollment.

4 Under the topic of reducing
5 burdensome administrative processes, we have
6 heard about the making the HMO licensing
7 process a biannual process, also requiring
8 electronic submission of HMO licensing and
9 accreditation filing materials, eliminating
10 the requirement to notify an insured that a
11 referral has been approved, eliminating the
12 requirement that HMO evidences of coverage
13 be sent into the Division of Insurance for
14 review, eliminating the requirement that
15 HMO's put premium on documents to covered
16 employees, eliminating the requirement that
17 HMO send annual provider directories to
18 employers, reducing rate filing requirements
19 for closed non-group health plans,
20 consolidate data reporting across state
21 agencies to reduce duplicative reporting,
22 enact legislation to ease the approval
23 process for the termination of closed plans.

24 Massachusetts residents are blessed

1 with some of the most technologically
2 advanced hospitals, best trained health care
3 practitioners and top ranked health
4 insurance carriers in the nation. This
5 comes, however, at a cost.

6 This cost can especially impact
7 small businesses. Between April of 2009 and
8 April of 2010, the average small business
9 health insurance rates increased by 12.4
10 percent.

11 We all know this is a complicated
12 problem that requires all stakeholders to
13 examine every available option. The
14 Division looks forward to issuing our report
15 in the coming weeks and working with you as
16 we move forward.

17 And with that, we would be happy to
18 answer any questions.

19 COMMISSIONER DAVID MORALES: Any
20 questions from the attendees for
21 Commissioner Murphy at this time?

22 If we don't have any questions --
23 oh, a question in the back -- Steve Bradley.

24 FROM THE AUDIENCE: Commissioner,

1 insurers that are facing this April 1st time
2 frame for issuing their new premiums, what
3 happens to those companies when, if they
4 issue those premiums based on their existing
5 data, and then their previous request that
6 they have submitted to the Division of
7 Insurance is denied or reduced and they have
8 already written those policies and they are
9 going to end up collecting premiums that are
10 not equal to what they are projecting their
11 costs to and let me follow up that, and then
12 if that happens, are you concerned that
13 there might be a run on the insurer where
14 policyholders that have higher premiums will
15 come back and demand that those premiums be
16 immediately reconsidered and lowered
17 potentially exacerbating the difference
18 between costs and revenue?

19 Thank you.

20 COMMISSIONER JOSEPH MURPHY: I
21 may defer to Kevin on part of the response.

22 We are in the process of reviewing
23 those rate filings that we received on March
24 2nd. As you heard the Governor earlier in

1 his comments, he recognizes that small
2 businesses are in an economic emergency. We
3 are in the process of reviewing those rate
4 filings. If we do disapprove a filing, we
5 have send guidance out to the company saying
6 that they would need to refund that premium
7 to those effected persons that are covered
8 under that disapproval.

9 DEPUTY COMMISSIONER KEVIN BEAGAN:

10 I would only add that we are looking at all
11 of the rate filings extremely carefully.

12 We have actuaries that consistently
13 look through the products to question all
14 the assumptions that have been used.

15 We are looking at all of the
16 filings at the same time to make sure we
17 understand the implications of any
18 disapproval.

19 We recognize that the disapproval
20 process will take time not only for the
21 Division to make its determination but if
22 the Division does determine that it is going
23 to disapprove any filing, then the company
24 has the right to then schedule an

1 administrative hearing and that hearing
2 would happen at the Division of Insurance in
3 the months that follow.

4 So we are trying to take everything
5 into account to make sure we understand the
6 implications of any disapproval.

7 COMMISSIONER DAVID MORALES:

8 Thank you, Commissioner.

9 At this time I would like to call
10 Len Nichols to the podium to begin his
11 presentation.

12 MS. DEBORAH CHOLLET: Good
13 morning, I am going to give a very brief
14 introduction to Len. You see his bio in
15 your packet.

16 Len Nichols is currently a
17 Professor of Health Policy and Director of
18 the Center, a new center -- Center for
19 Health Policy Research and Ethics, College
20 of Health and Human Services at George Mason
21 University. He came to that position from
22 the position of Research Director, I guess,
23 of the New America Foundation and has -- was
24 the Vice President For the Center for

1 Studying Health System Change, a principal
2 research associate at the Urban Institute
3 and the Senior Advisor for Health Policy at
4 the Office of Management and Budget during
5 the Clinton reform years.

6 Len comes with all of the nicks and
7 bruises and deep cuts of health care reform
8 and price control and we will let him talk
9 about that.

10 Thank you.

11 PROFESSOR LEN NICHOLS: Well,
12 thanks, Deborah, Commissioner Morales, and
13 other distinguished guests -- I would like
14 to thank you for inviting my testimony today
15 on the urgency of finding policy solutions
16 to our health care costs problems at the
17 local, state and federal levels.

18 My name is Len Nichols. I am a
19 health economist, a Professor of Health
20 Policy, a Director of the Center for Health
21 Policy Research and Ethics for George Mason
22 University in Fairfax, Virginia which you
23 may know that is the southern-most
24 Commonwealth in the United States.

1 I am honored to offer this
2 testimony today not least because I lived
3 and voted in Massachusetts for 11 years when
4 I began my career as teaching and eventually
5 chairing the Economics Department of
6 Wellesley College.

7 And my son was born at the Brigham
8 in 1987, so I actually have a deeper
9 connection to Massachusetts than any of you
10 could possibly know.

11 And Massachusetts has always been a
12 beacon to our nation from before it was a
13 nation right up until and including this
14 morning.

15 Our political leaders at the moment
16 are engaged once again in a great national
17 debate about whether to use government power
18 to set new rules in the Senate so that our
19 health care system can serve all of our
20 citizens in an economically sustainable
21 manner or not.

22 And, once again, all eyes are on
23 Massachusetts. You have led the way in
24 implementing the law and policy that has

1 reduced the percentage of your population
2 without health insurance to a level that the
3 rest of the country can only envy.

4 And, once again, you helped fellow
5 Americans see what is possible and in many
6 important ways, it helped perform
7 legislation that the Congress will finally
8 vote on in the coming days and weeks is
9 patterned after your own.

10 But just as the fate of national
11 reform hangs in the balance, you too have
12 much unfinished business with your policy
13 choices as well. For the common issue that
14 vexes Massachusetts and national, political,
15 business, health system and thought leaders
16 is what to do about health care costs. This
17 issues is perhaps the primary conundrum in
18 the national debate and, of course, you
19 already know that if you fail to address it
20 accurately, your own stellar coverage gains
21 will come undone and your own middle class
22 will find access to timely high quality of
23 care increasingly out of reach as it is
24 already in the rest of the country.

1 This is and would be a failure of
2 leadership of a very high order.

3 So what is to be done?

4 There is, of course, no shortage of
5 advice on this score and you will hear and
6 read more than your personal share of the
7 very best kind this week and afterwards.

8 I happen to know how smart and well
9 informed the people are who live nearby and
10 want to help you make the right choices for
11 Massachusetts.

12 My task this morning is to set the
13 context for why you must act while being
14 paralyzed by a complete lack of certainty by
15 so confusion and by partisan demagoguery is
16 dangerous for Massachusetts and for our
17 country.

18 Let me begin with what I think is
19 the graph that conveys all other ideas.
20 This is why we are having this conversation
21 as a nation and it is why we must act to
22 reduce costs.

23 It shows the ratio of family
24 premium to medium family income across the

1 country in various years.

2 '87 is the first bar and I picked
3 that year because it is a year for which we
4 happen to have very good data. In 1987 the
5 family policy took about 7 percent of median
6 family income, and that of course is the
7 income that half make more and half make
8 less.

9 Go out one bar and you get to 2006
10 and I picked 2006 for an important reason.
11 That is the year when the candidates in 2008
12 for President make a go/no go decision.
13 They have been to Iowa four times. They
14 have seen how they look in flannel shirts
15 and they learned to talk like farmers and
16 they decide to run or not.

17 And isn't it interesting that 20
18 candidates both parties felt compelled to
19 have a health care plan at this time. Why
20 is that? It is not because they want to
21 talk about health care reform -- trust me --
22 they would much rather than talk about
23 Pakistan.

24 It is because the middle class is

1 worried about how to pay for it and the
2 reason is right there. It is because by
3 2006 the family policy was 17 percent of
4 median family income.

5 Now if you take the last ten years
6 and trend out ten more years from that 2006
7 magic moment -- just let premium grow like
8 it has and median income grow like it has,
9 you will get to a choice about your religion
10 about economics. If you believe what
11 economists believe and that is that employer
12 contributions have to be paid for out of
13 productivity and do, therefore, come out of
14 wages -- then you have to count employer
15 contributions as part of income as I do in
16 the first two bars.

17 If you believe that, then you count
18 it and then ten years from now health
19 premiums are only going to be 34 percent of
20 median family.

21 If you believe what some of my
22 friends in the labor movement believe and
23 that is that it comes out of wage -- out of
24 profits and then you don't count it as

1 income, it comes to 45 percent.

2 Now truth, of course, I will tell
3 you is somewhere in between. The truth
4 always is. But I will tell you this too in
5 economics we have concepts for something
6 between 34 and 45 percent of median
7 income -- it ain't going to happen. It is
8 not going to happen. We cannot go there. We
9 cannot afford that. That is the fundamental
10 point. We cannot afford business as usual.
11 We are not going to move to a world in which
12 half of our population pays a third or more
13 of their income to cover the payment, it is
14 not going to happen. So something has to
15 change.

16 This is the next reason -- oh, let
17 me back up, sorry. These are all national
18 data. In Massachusetts, you know, you are
19 rich, right, you have very high incomes and
20 it turns out you also have high premiums, it
21 turns out you have a little bit higher
22 income than you do premiums. So you right
23 now in 2008 only need 16 percent of median
24 family income to pay for a family policy.

1 But you are on the same trajectory as
2 everybody else. In fact, what I learned
3 this morning is that you are actually on a
4 worse trajectory than everybody else so
5 you too will get to the mid 30's by
6 yourselves.

7 This is the next reason. We don't
8 really have a choice. Now this shows
9 Medicare -- I won't belabor Medicaid -- I
10 assume you all know about that since you
11 deal with that every hour, but Medicare
12 drives home the point at the Federal level,
13 of course, the main reason for our fiscal
14 imbalance which is serious is Medicare cost
15 growth and this is the simplest way to look
16 at it -- it is shows the share of GDP that
17 Medicare claims, 2008 3.2, ten more years
18 2020, 4.5 that would be a one third
19 increase, that means to keep it as solvent
20 and as functional as it is now that means
21 you would have to raise taxes for Medicare
22 by one third and keep going it gets worse as
23 boomers retire and age and as current health
24 care costs growth continues.

1 So what that says is that we have
2 to increasingly give up larger and larger
3 fractions of our total output at the Federal
4 and State level just to maintain the
5 promises we have already made.

6 Then you don't really have a
7 choice. Sometimes the hardest choices are
8 when you have no choices at all. We are
9 going to have to address this.

10 Again, in Massachusetts you look
11 like a very high spending state if you just
12 look at unadjusted data. The amazing thing
13 about the team Stan assembled is that they
14 did all the right adjustments and that gets
15 your utilization down to pretty much
16 average.

17 Well, I am here to tell you you
18 shouldn't be proud of being average in
19 utilization in the Medicare program. You
20 are right there like everybody else. You
21 should do better. In fact, if you don't do
22 better in Massachusetts, just think what it
23 is going to be like where people talk like I
24 do. It is not going to go do well in

1 Mississippi, Arkansas, Louisiana and so
2 forth if y'all don't lead the way. I will
3 have a seminar on how you say y'all.

4 But anyhow we need you to get after
5 this a bit more intensely -- and here is
6 why. This is from the Congressional Budget
7 Office and we know they do a lot down there
8 to save paper so I apologize for the number
9 of ideas in this one graph, but it has two
10 reports.

11 One is a bar chart -- I'm sorry,
12 the line, the line graph which is the most
13 important number actually in this discussion
14 of the deficit and that is the debt held by
15 the public -- that is we owe each other --
16 as a fraction in GDP so it represents in
17 some sense our indebtedness relative to our
18 national output and you want to read that
19 against the right hand scale and what you
20 see is that the least recent excitement has
21 got us up from avoid 40 percent of GDP to
22 over 60 -- it is actually about 67 rising
23 slightly over time if the current law
24 continues. That is an important number. It

1 is a big jump and I want to put it in
2 historical context in a moment but right now
3 I want you to take that in your head and
4 then focus on the bar charts because the bar
5 charts show us the fraction of GDP right
6 against the left hand scale that we spend on
7 interest.

8 Today is it is about 1 percent of
9 GDP on interest and within ten years it will
10 be 3 percent of GDP and rising.

11 Now moving from 1 percent of GDP to
12 3 percent of GDP does not excite many people
13 who aren't economists. I agree with that.
14 But let me tell you a secret -- that is big
15 money. 2 percent of GDP more to get us
16 exactly what in terms of services for our
17 population -- zero.

18 To put this in perspective to cover
19 the uninsured nationwide would cost one
20 percent of GDP. So when you squander 2
21 percentage points more on interest, you are
22 squandering in the easy case for covering
23 the uninsured and that is why it is becoming
24 so hard in Washington to have a conversation

1 about this. So we have to get our dent
2 down. Now let me get you in context here
3 because there is nothing better than history
4 to do that.

5 This is debt to GDP over a longer
6 time frame and I want you to understand
7 this. It is actually fairly rarely
8 discussed which it is unfortunate for a
9 nation.

10 I want to take you back to
11 World War II and show you we started at 40
12 percent GDP, and debt held by the public
13 went up to 110 percent -- why -- because we
14 had to borrow to build all those battleships
15 and B17s to go tearing around the globe.
16 That turned out to be a good idea. We
17 didn't really have a choice then we had to
18 do that and, no, we did that and kept the
19 third grade and Mass. General open. We
20 managed to this because you borrow when you
21 have to.

22 But then, and this is really
23 important, starting in '46 we had what we
24 had lost and we had a bipartisan consensus

1 to pay off the debt overtime.

2 It is possible. We had it once.
3 We had a bipartisan -- look it went down
4 from 46 all of the way a little pick up
5 around OPEC basically the rates and that is
6 when we lost the bipartisan consensus and as
7 an economist I will tell you you can have
8 whatever size government you want but you
9 have to pay for it.

10 If what you start doing is cutting
11 taxes without cutting spending, then you are
12 saying you are not willing to pay for the
13 government you want. That is a problem.

14 And note the debt from GDP went
15 from about 25 percent up to over 47 percent
16 while the economy was booming.

17 And then Clinton with a fair bit of
18 uncooperative help from Gingrich, they sort
19 of fashioned an involuntary bipartisan
20 consensus but they did -- God love them
21 both -- and they started to turn it down and
22 so we actually remember when Clinton left
23 office, Republicans were in the Congress and
24 had a 200 billion dollar surplus. Where did

1 the hell did that go?

2 Then what happened, of course, W1
3 wanted to cut taxes again. We don't have a
4 bipartisan consensus about paying for tax
5 cuts, our wars, our Medicare and then --
6 boom -- the great recession hit.

7 I want use the D word, I don't want
8 to panic civilians. It was not a
9 depression. But it was not a depression
10 mostly because we knew about the last
11 depression to intervene -- remember Paulson
12 and Biernacki going up to Congress in
13 October '78. I will never forget it
14 interrupted playoff baseball. There I am
15 wanting to see the 7th inning and I get
16 Nancy Pelosi on TV.

17 And what you saw was a tremendous
18 amount of fear, why -- because Biernacki,
19 the economist, thank God was in that
20 position and actually understood the Great
21 Depression and spent his whole life
22 studying -- okay, for all of your students
23 out there -- it is a good thing to study one
24 thing forever -- your day will come -- and

1 at that moment he was the one guy in the
2 right spot who could tell members of
3 Congress we don't have a choice, sports
4 fans, you have got to borrow and spend money
5 because we face an existential threat to our
6 way of life just as serious as World War II
7 and every macroeconomist on the planet
8 agreed we have to spend money and so we did.

9 Now it turns out that blip in the
10 GDP was partly due to the Bush tax cut plan
11 and partly due to the stimulus. The
12 stimulus itself added about 25 percent of
13 that surge -- that ain't the problem. We
14 had to borrow to keep from having a
15 depression. The problem is what happens
16 next.

17 The problem is we don't have a
18 bipartisan consensus about how to bring that
19 debt down. That is why we are locked into
20 ever increasing interest payments and that
21 is why we are locked out of squeezing out
22 the priorities we all share about how to
23 make the country and state decent and strong
24 at the same time.

1 So when I look at health reform at
2 the national level from a fiscal
3 perspective, it is only worth doing if it
4 begins to reduce the deficit which according
5 to the non-partisan Congressional Budget
6 Office, it does.

7 So to argue against health reform
8 on deficit grounds is frankly a kind of
9 intellectual dishonesty of a rather high
10 order. We are used to that, of course, so I
11 couldn't belabor the point.

12 I will just say that the important
13 stuff about health reform is actually not
14 what CEO score slightly reduced the deficit.
15 The importance is what CBO didn't score and
16 that is the payment reform stuff at the end,
17 all right, all of that stuff about
18 accountable organizations, medical home, the
19 conversation is quite similar to what I am
20 hearing here.

21 In fact, of course, your work is
22 very much being watched in Washington
23 because you had the courage to make the
24 first step.

1 We all pray you have the coverage
2 to take the second step and then the people
3 down there will have the courage to make the
4 first step.

5 So what is the deal -- I would say
6 you are going to hear a lot more about
7 solutions coming forward my task was to make
8 you sort of believe A, you can and B, you
9 got to take serious steps and save costs
10 overtime.

11 What I would say is the one issue
12 that has not gotten nearly enough attention
13 either analytically or frankly politically
14 is the reality of local market power.

15 Now the Attorney General report is
16 going to speak for itself and I won't step
17 on her toes. I will just say read it, read
18 it again, read it a third time, think about
19 it hard. It is real.

20 Now the problem from the economics
21 point of view is that when you have got real
22 market power, you have only got three tools,
23 antitrust, regulation and countervailing
24 market power. I will tell you that you are

1 going to need them all but the truth is
2 antitrust can't help you much if what is
3 going on is legal and lots of it is legal --
4 maybe all of it for all I know so you are
5 kind of stuck if the problem is derived from
6 a reputation that is in people's minds --
7 more powerful than data at least the data
8 that I have seen so far. Maybe I should see
9 more data -- I will leave that to you. But
10 the point is it can't help you much in every
11 case.

12 Regulation is the temptation of
13 everybody in a hurry and Lord knows we
14 should be in a hurry and you know, one of
15 the reasons that I have been around as long
16 as I have is I'm so old I am in a hurry too.
17 This is my last shot, okay, but I am going
18 to tell you that regulation also smacks up
19 against all sorts of instincts that are good
20 in the American market system and,
21 therefore, you want to go carefully down
22 that path and I would say avoid it if you
23 can, therefore, you are left with what I
24 think is the most important and useful tool,

1 countervailing market power, i.e, buying
2 power.

3 That includes the power to regulate
4 information flows so we can get more
5 transparency out there.

6 Transparency may end up being your
7 best friend particularly with public opinion
8 about reputation and so forth. Performance
9 should match that or not but first you have
10 to show what performance is.

11 So I would just say pay close
12 attention to countervailing power. Three
13 elements there -- first, just like the
14 Federal bill does, you have got to signal
15 business as usual is over. Business as
16 usual has to end because we can't afford
17 business as usual any more. We simply
18 cannot afford it.

19 We just went through that class, we
20 cannot afford that, so we have to do
21 something different. The signal that
22 business as usual is over is extremely
23 important in a world that is pretty
24 decentralized by health care costs. Because

1 what you really need is not a bunch of smart
2 people sitting in some room and mail out the
3 answer, you need participation by your local
4 providers which are different throughout
5 this Commonwealth.

6 You are not going to get full speed
7 participation and engagement in thinking
8 about new incentive and measurements
9 structures unless they know that the status
10 quo is going away.

11 So it is a signal that leads to an
12 engagement of behavior that you need to make
13 in my view appropriate policy and health
14 care choices.

15 And, second, a lot of people have
16 concluded and I am certainly among them a
17 fee for service of 10,000 CTP codes is
18 probably not the smartest system for the
19 21st century. You are not going to get
20 efficiencies if you are arguing what you
21 paid for a particular code. It is not going
22 to happen. You need to broaden the scope of
23 what you pay for and broaden the
24 accountability measurement that you are

1 actually holding -- that you are going to
2 pay forward.

3 But I will tell you and the
4 Attorney General makes this point quite
5 clearly just ending fee for service alone is
6 not enough. You can still have a market
7 power problem and have it all bundled. You
8 have to deal with market power or you are
9 not going to get where you want to be and,
10 finally, and this is a lesson that I would
11 say that came to me partly through the
12 Center for Studying Health Systems Change
13 and partly through Stan and Stuart Altman's
14 group at Brandeis and partly through what I
15 have been through in the last couple of
16 years trying to figure out how to create
17 space for a decent policy conversation in
18 the District of Columbia which is a
19 challenge.

20 It turns out that one of the things
21 we need more of are progressive private
22 sector voices. I will say something I think
23 probably a lot of people would agree with --
24 no single human has enough wisdom to solve

1 this problem and I guarantee no human in
2 government in Washington has the wisdom to
3 solve this problem.

4 But I predict that it is probably
5 true in Massachusetts too although you do
6 appear better than average I will assert.

7 So you are going to have to listen.
8 In fact, I would say as a nation, our
9 biggest problem right now is we don't know
10 how do listen to each other any more. I
11 don't know what the hell happened there but
12 we need to learn to do that again. We need
13 to listen to the private sector and the
14 problem is you can't just do the easy ones
15 and pick trade associations. Some of my
16 best friends are in the trade
17 associations -- let me make that clear but
18 trade associations are all flawed. They are
19 all too big. They all grow to get clout
20 that is human and normal but then it ends up
21 they have to protect their weakest members
22 and so they end up having to suppress the
23 progress -- the voices you need to listen
24 to. So you need somebody else to bring you

1 the progressive voices -- I volunteer myself
2 and Stan and Stuart and so forth.

3 But any way the point is here is
4 what they taught me. First, thing about, in
5 fact, try to implement the concept of
6 evidence based regulation to go along with
7 evidence based medicine -- and by this I
8 mean let's think about the redundancies that
9 we have right now in all kinds of quality
10 financial and even educational regulations.
11 I know a very, very high quality public
12 health system in Denver is inspected by
13 eight different creatures every year, same
14 check list for quality, same health and
15 performance and the CEO has to spend eight
16 weeks a year with different people all
17 basically trying to find out that she is as
18 good as her numbers look like.

19 We have a word for this -- it is
20 called stupid. We need to do better than
21 this and we can do better than this and you
22 surely can think about similar types of
23 redundancy that can be overcome.

24 Second, we are America. We are not

1 going to go to single payer. We are going
2 to have multiple payers. That is one of the
3 benefits of our system and one of the
4 sources of inefficiency.

5 So if you think about sharing very
6 good incentive information and I would say
7 quality information across payers so we all
8 have similar incentive structures.

9 Why should a hospital have 14
10 different pay for performance schemes -- God
11 help us all. That may require by the way
12 some creativity about regulation, again,
13 why -- because you may need state anti-trust
14 people to help up with the feds so they can
15 all get in the room and talk. Right now you
16 can't assemble all of the payers and
17 providers in one community and talk about
18 incentive structures -- it is illegal.

19 We also think that that is stupid
20 economics and you have policy makers that
21 can help you fix that and I believe you can.

22 Third, the private sectors folks
23 who run real systems around the country who
24 I consider to be progressive voices are

1 quite clear on this point -- just tell me
2 what the incentives are and get out of the
3 way but reward me for doing the right thing
4 and punish my brethren who don't.

5 There is no reason on earth that we
6 should be as tolerate about subpar
7 performance and high cost activity as we
8 have been as a country and I predict as you
9 have been as a state.

10 And, finally, on this point of no
11 one has pure wisdom, think about making a
12 public private partnership, the task of
13 which is to teach best practices everywhere.

14 Some hospital in Worcester figures
15 out a way to make sure we never have a
16 central will line infection again -- that
17 knowledge ought to be nationwide in less
18 than a year.

19 Now your own Institute of Health
20 Care Improvement in down in Berwick does a
21 great job of pushing that and as far as I
22 can tell about 200 hospitals out of 3,500 in
23 the United States really are benefiting in a
24 serious way from that flow of information.

1 That would be a low percentage and we can do
2 better than that is but only if we make it
3 clear business as usual is over and we have
4 to move to a better world and I thank you
5 for your time.

6 (Applause from the Audience.)

7 MS. DEBORAH CHOLLET: Do we have
8 any questions immediately? Yes --

9 FROM THE AUDIENCE: Now, I am
10 wondering what are the incentives for
11 physicians or hospitals that develop best
12 practices to actually propagate and
13 disseminate that information?

14 PROFESSOR LEN NICHOLS: Good
15 question.

16 FROM THE AUDIENCE: And the flip
17 side, what are the dis-incentives or
18 incentives for people with bad practice to
19 abandon bad practice?

20 PROFESSOR LEN NICHOLS: Very good
21 and it is quite symmetric -- I love the way
22 you bracketed that question.

23 Let me first say the incentive of
24 those who figure out the best way to spread

1 is not great unless you reward them for
2 constantly finding it.

3 So what you want to do is build in
4 a system where if you get there first, you
5 get the most savings.

6 So let's imagine Hospital A learns
7 how to reduce, let's just say treatment of
8 knee surgery with high quality outcomes and
9 all of the stuff we always measure and they
10 are 20 percent below the average.

11 Well, then you want to give them a
12 payment that allows them to reap that gain.
13 So there is their gain. Then you say to the
14 other ones, look, if you can do this, you
15 too can share in the savings and by the way
16 here is how, all right, and over time we all
17 can get there and meanwhile the one that is
18 doing the 20 percent maybe gets a grant to
19 study to do more and so forth, maybe the
20 hip, shoulder.

21 So you have to constantly reward
22 the innovators but you have got to make
23 clear we want the whole country or the whole
24 state to get to this 20 percent below

1 average. We are all be going to be lead woe
2 be gone, by God. Trust me, there is enough
3 overuse out there in say Florida and Texas
4 and Mississippi and you have always got
5 those guys to compare to and hopefully the
6 Federal government will get its act together
7 and they will start driving the system as
8 well.

9 So the first thing is you want to
10 have incentives to innovate and reward them
11 for high quality performance.

12 Right now if they got better at
13 reducing central line infections, etc., they
14 just give money back. There is no incentive
15 to innovate right now.

16 So the flip -- what about those who
17 are bad -- why should they gain -- well,
18 that is the point of changing the payment
19 mechanism.

20 Right now there is no incentive and
21 frankly unfortunately right now there is no
22 time, you guys are busy as hell, all right,
23 and you take a primary care doc -- they have
24 to see 30 or 35 patients a day to make a

1 living -- they don't have time to read, they
2 don't have time to eat lunch.

3 So when you think about your going
4 to have to teach them and you are going to
5 have to make it easy for them -- that is
6 what this public private partnership is
7 about is to make it such that -- but that
8 won't work alone -- just tell them there is
9 a better way -- unless you incentivize it --
10 unless you make it clear that they are going
11 to gain financially.

12 The ideal in primary care, for
13 example, would be to move to a world in
14 which they could make a living seeing 20
15 patients a day and you talk to primary care
16 doctors and they will all tell you a lot of
17 those visits are not really necessary. They
18 are redundant follows up because they have
19 to order them in order to make a living.

20 So let's change the way they make a
21 living to a more efficient structure. They
22 make more money seeing fewer patients but we
23 manage all 35 better and use more nurse
24 practitioners and so forth -- so a

1 combination of incentive and information and
2 I would say pressure, countervailing power,
3 we will not pay unless you do the following
4 once we know it is the right thing to do
5 within some reasonable span of time.

6 MS. DEBORAH CHOLLET: We have a
7 question.

8 FROM THE AUDIENCE: Thank you for
9 the presentation. It is so concise. And it
10 is nice to be able to have a conversation
11 after it.

12 Have you identified in all of this
13 any -- in a safe way -- the major
14 resistances to doing this? Is it all money?
15 Is it power? They are veiled sometimes but
16 any thoughts about that?

17 PROFESSOR LEN NICHOLS: When
18 certainly when people say they are not
19 talking about the money, you can often
20 assume that the money is in the room, but I
21 think it is also true it is more than money,
22 it is absolutely more than money. Part of
23 it is autonomy, it is belief that, you know,
24 I am supposed to do it this way, that is

1 what they were taught maybe and/or it is a
2 way that they think they have to do it to
3 make a living.

4 What is fascinating I am sure you
5 know is this geographic variation around the
6 country, within the state, and probably even
7 within the city -- and you sort of how can
8 this be -- well, when they got to where they
9 are whether it can be Utah or some
10 particular hospital in Massachusetts this is
11 the way we do things and that is what they
12 are taught.

13 So remember in medical school very
14 rarely are they taught anything about how to
15 actually set a price. So there is a whole
16 lot of learned economics once they leave
17 medical school and then I would just venture
18 the observation within medical school they
19 are not taught appropriately enough about
20 parsimonious issues of resources. They are
21 taught go try what you want, let's try not
22 to kill them and we will come back and learn
23 from this. So fundamentally if we don't
24 teach them efficiency -- if you don't teach

1 them efficiency when they are young and they
2 can make a better living being inefficient
3 when they are old -- what are they going to
4 do?

5 FROM THE AUDIENCE: Education.

6 PROFESSOR LEN NICHOLS: So it is
7 a combination of education, changing
8 incentives and then give them a pathway and
9 you can't just say, okay, I am going to pay
10 you more for this and less for that unless
11 you teach them to do the right thing and
12 that is why I think the public private
13 partnership essentially think of it like the
14 tool used -- the tool used in this New
15 Yorker piece on, you know, how we learn
16 overtime, like the Agricultural Extension
17 Service has a county agent in every county
18 in the United States out there teaching the
19 farmer down where I live and everywhere
20 else, maybe you want to thicken about beans
21 because cotton ain't doing too well -- so
22 think about it -- why not have the same kind
23 of resource available to a doc trying to
24 move from a 35 visit day to a 20 visit day.

1 I know a practice in eastern
2 Tennessee, a guy figured out that the
3 elderly need more time -- that is a shock --
4 so he ran a bunch of physicians practice --
5 he created a separate practice just for the
6 elderly but he had to go through sheer hell
7 to do it but he forced his physicians to
8 spend 40 minutes per elderly patient --
9 culture shock -- they are used to is 9 or 11
10 even for the elderly -- 40 minutes --
11 apparently first they sang a song. But
12 anyway, 40 minutes when you do this, you get
13 a really good history and you learn what is
14 going on, lower admissions, about 18 percent
15 and lower EDs by 40 percent and had them all
16 healthy but then he figured out he was
17 basically giving money back to the Medicare
18 program. So he created a health plan to
19 capture the full payment and he used the
20 surplus to incentivize the docs to do what
21 they knew they should do in the first place.
22 Now the docs are happy, everybody is happy
23 except the Medicare program because it
24 doesn't like -- but you get it -- it is both

1 money and culture -- you have to do both --
2 you can't ignore either.

3 MS. DEBORAH CHOLLET: Let me
4 follow up on that.

5 There are always two impediments
6 to a in State C to private public
7 partnership certainly the outliers are
8 protected by Federal law and that is
9 Medicare and business plans.

10 How do you see them playing into a
11 public private partnership and coordinating
12 it?

13 PROFESSOR LEN NICHOLS: I think
14 we are going to hear this afternoon that the
15 ERISA plans are tired of paying what they
16 pay for health care.

17 And I think what stunned me about
18 your trend in Massachusetts was how the
19 ERISA plan trend is worse than the
20 commercial plan. That may be a first in the
21 United States. I am very impressed with it,
22 how bad that is.

23 So I think, in fact, they are
24 likely to be highly motivated and since you

1 know quite well since you taught both of us
2 about this, the ERISA plan is mostly
3 self-insured so they are really with
4 providers.

5 At the end of the day it is about
6 the physician/patient encounter, everything
7 else is commentary.

8 You said it -- if we don't get this
9 right, we are not going to get anything else
10 right. So it is really about how do you get
11 to there.

12 Now as far as Medicare, what one
13 would hope although one might not want to
14 bet on it, but what one would hope is that
15 the Federal government will get their act
16 together and make Medicare a partner.

17 One of the most interesting things
18 in my view about the Centers for Payment
19 Innovation and the language of the bill as
20 well as some language that is already there,
21 Section 646, I think it is, communities have
22 the right to in a sense ask for the right to
23 be free of all of those in order to do what
24 the community wants to do.

1 Let me tell you a secret -- we are
2 not going to solve this problem at the
3 Federal level in one felt swoop. It is
4 going to have to be done community by
5 community. Every kind of community is
6 different with different kinds of hospitals,
7 physicians and configurations but if you
8 agree you want one set of incentive
9 structures and you want one set of
10 measurements that make sense and you get
11 providers to buy in then you have a chance
12 to go and say here is what I would like to
13 do -- there is a concept out of the Recovery
14 Act associated with Beacon Community, I
15 assume they took the name from here, in any
16 way those Beacon Communities are going to be
17 I think multi-payer experiments in the
18 making of efficiency and high value of care.

19 FROM THE AUDIENCE: I wonder if
20 you could speak about the way prevention
21 plays a role until terms of costs and
22 controlling inappropriate use of health
23 care -- both prevention in the context of a
24 clinical visit and a broader more community

1 based approach to venture.

2 PROFESSOR LEN NICHOLS: Okay, let
3 meal talk a little bit again about Denver
4 Health -- that is a public system that I
5 know a lot about and I have seen it up close
6 and then talk about the broader public.

7 Denver Health, and by the way
8 two-thirds of their patients are either
9 uninsured or Medicaid and yet they get
10 quality scores off the map and they are
11 two-thirds of the cost of their competitors.

12 So how do they do it. They have a
13 screen on which the electronic record sits
14 and the physician has to turn the screen
15 literally this much so the patient and
16 physician can look at it at the same time
17 and that allows them to show these patients
18 and here is the line for your blood
19 pressure -- what happened here -- you didn't
20 fill your prescription -- next time you
21 don't fill -- when you can't afford it, you
22 tell me and we will get you the drugs
23 because what happens when you don't -- what
24 happens is that little blue/red graph --

1 they have the best compliance in
2 hypertensive control in the United States.
3 All non-verbal, I mean all non-written -- it
4 is all conveyed to the population that is
5 typically considered to be a troubled
6 population.

7 Take that to the bigger scale --
8 fundamental problem as you know quite well
9 is prevention is a good idea -- the payoff
10 to investment is it is not a short run
11 payoff.

12 So you can't expect private actors
13 to invest -- it has to be invested in at the
14 public level. It has to be public.

15 So I would submit that no one in
16 our business can look at obesity trends and
17 not be truly terrified about where we are
18 headed.

19 I mean, you know, in my opinion we
20 have to make both information incentives a
21 much stronger component. I applaud what
22 Senator Harkins, a good card carrying
23 liberal supported that is now an
24 amendment -- a penalty for smoking. I hate

1 it and you ought to be able to avoid it if
2 you enter an approved smoking cession
3 program but you should not be able to avoid
4 it just by saying I don't want to do
5 anything. I would say the same thing for
6 obesity, the same thing for all of the
7 other things.

8 You have to turbo charge the
9 incentives but you also have to, I think,
10 you give them a pathway, you can't just say
11 go by skinny -- you have to say here is how
12 to do it.

13 FROM THE AUDIENCE: I am Lynn
14 Nicholas.

15 PROFESSOR LEN NICHOLS: Oh, yes,
16 yes.

17 FROM THE AUDIENCE: And I really
18 appreciate your comments other than the dig
19 about the trade associations.

20 (Laughter from the audience.)

21 PROFESSOR LEN NICHOLS: I said
22 some of the best people are in it, but any
23 way --

24 FROM THE AUDIENCE: So here is my

1 question. Your comment about, you know, the
2 progressives and letting them kind of lead
3 the market trends, I think, has great value.

4 PROFESSOR LEN NICHOLS: Which is
5 how we met if I recall.

6 FROM THE AUDIENCE: That's right.
7 So how do you deal though with the fact that
8 in that kind of milieu the strong will
9 probably get stronger and the weak will
10 probably get weaker and then there is the
11 whole issue of consolidation or, you know,
12 the diversity of what we have versus market
13 leveraging and consolidation, so how do you
14 see that issue and that trend which is a
15 national trend which is not apparent here in
16 Massachusetts that much -- how do you see
17 that playing into all of this -- as
18 something we should encourage or discourage
19 or, you know, what is your view on that?

20 PROFESSOR LEN NICHOLS: Well, I
21 will would say you have hit in many ways the
22 nail on the head here as to the tension
23 between these impulses and realities.

24 But I would just start by asking

1 this question -- who would we rather have
2 run the small in efficient hospitals in
3 Nebraska -- somebody who knows what they are
4 doing or someone who doesn't.

5 So I think in fact it is okay if we
6 have consolidation in a certain form. What
7 you don't want is for that consolidation to
8 lead to price advantages which are not
9 commensurate with value delivered.

10 What I hear in the data although I
11 have not seen any econometrics, so I will
12 reserve judgment but what I hear what I have
13 seen in the report so far is prices in
14 Massachusetts are not correlating with
15 anything except market leverage.

16 So what I think is we have to think
17 hard about what the consequences are. To me
18 the solution, again, is some combination of
19 appropriate transparency, countervailing
20 power and better payment policy which will
21 enable folks to make the better living doing
22 the right thing the first time as opposed to
23 just using pricing power to cover up many
24 sins.

1 You probably know and I am sure you
2 do, roughly today according to MED PAC data
3 three fourths of hospitals lose money on
4 Medicare, but they almost all have positive
5 total margins and they make it up by
6 charging private payers a hell of lot more
7 than they lose in Medicare.

8 While that sort of works, it is not
9 good. The problem is not that Medicare
10 underpays per se, it is that hospitals are
11 covering up inefficiencies with market
12 power.

13 So we have to think about ways to
14 enable them to make a living in the right
15 way -- we need to pay them -- we need to pay
16 them better for Medicare -- most of the
17 country -- I don't know what it is like here
18 but I assume it is better here than in most
19 places.

20 FROM THE AUDIENCE: NO.

21 PROFESSOR LEN NICHOLS: I am sure
22 it is less than cost but in Colorado it is
23 like half costs and in California, I mean,
24 what is the point.

1 So they basically -- we have to pay
2 better for the right, you know, for
3 different payers but at the same time we
4 have to incentivize increasing total quality
5 improvement or we can't forward move.

6 So I think there is a balance
7 there. I am not afraid of consolidation as
8 long as it doesn't lead to undue market
9 power.

10 What it should lead to is higher
11 quality and lower cost.

12 MS. DEBORAH CHOLLET: I need to
13 close the session to stay on time.

14 Thank you, Len.

15 (Applause from the Audience.)

16
17 COMMISSIONER DAVID MORALES:
18 Thank you very much, Professor.

19 At this time I would like to invite
20 John Ciccarelli, our Associate Vice
21 Chancellor at UMass Boston to the podium
22 where he is going to give us our
23 instructions for lunch.

24 I would like to thank him publicly

1 for hosting this.

2 Thank you very much for hosting
3 this.

4 ASSOCIATE VICE CHANCELLOR

5 CICCARELLI: Okay, folks, listen closely.

6 You go down to the second floor and
7 the second floor puts you on the cat walk.
8 If you go to the left, you go to the campus
9 center, and at the UL level, UL, there is
10 the Atrium Cafe and you can get sandwiches,
11 soups and other delectable items.

12 If you get on the cat walk and you
13 go to the left, you can go to the Quinn Cafe
14 which is in the Quinn Building, again, at
15 the UL level and there is soups, beverages,
16 etc.

17 We apologize but it is spring break
18 and a longstanding renovation on the
19 cafeteria began this weekend which will
20 conclude at the end of the week.

21 You have a little walk but you can
22 stretch your legs and there are sandwiches
23 and things there and we look forward to
24 seeing you back here.

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(Whereupon at 12:45 p.m., the
lunch recess was taken.)

C E R T I F I C A T E

COMMONWEALTH OF MASSACHUSETTS

Norfolk, ss.

I, Maureen Nashawaty, a Registered Professional Reporter and Notary Public in and for the Commonwealth of Massachusetts, do hereby certify that the foregoing transcript taken on Tuesday, March 16, 2010, is true and accurate to the best of my knowledge, skill and ability.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 5th day of April, 2010.

Maureen R. Nashawaty
Registered Professional Reporter

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Massachusetts Health Care Cost Trends Final Report

Appendix C.5b

Health Care Cost Trends Public Hearings

Transcript for Afternoon Session Tuesday, March 16, 2010

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THE COMMONWEALTH OF MASSACHUSETTS
DIVISION OF HEALTH CARE FINANCE AND POLICY

ANNUAL PUBLIC HEARING UNDER
M.G.L. c. 118G, SECTION 6 1/2
HEALTH CARE PROVIDER AND PAYER COSTS
AND COST TRENDS

PANEL:

David Morales, Commissioner, Department of
Health Care Finance and Policy
and Chair of Public Hearings

HELD AT:

University Club, 11th Floor
Joseph P. Healey Library
University of Massachusetts, Boston
100 Morrissey Boulevard
Boston, Massachusetts 02125

Tuesday, March 16, 2010 Afternoon Session
Commencing at 1:20 p.m.

COPLEY COURT REPORTING
The Mercantile Building
71 Commercial Street, Suite 700
Boston, Massachusetts 02109
(617) 423-5841

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2) **Eric Michelson**, Michelson's Shoes-**Page 56**

3) **Michael Widmer**, President, Massachusetts
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4) **Nancy Turnbull**, Senior Lecturer on Health
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PROCEEDINGS

COMMISSIONER MORALES: We're going to get started with the second part of our hearing today with Attorney General Martha Coakley, so, Attorney General, whenever you're ready.

MS. COAKLEY: Good afternoon everybody, thank you, Commissioner Morales, and thank you, Commissioner Auerbach and Attorney General O'Brien and Commissioner Murphy who was here this morning, for those of you who were here a very interesting morning that we hope to continue.

In addition to our Health Care Division Chief Tom O'Brien, I just want to introduce who else is here today from the Attorney General's Office, Lois Johnson who is an Assistant Attorney General who is going to make a presentation once I make some brief remarks, and also Assistant Attorney General Karen Sung and Susan Brown are here and seated with Lois are two of our experts, Dr. John Freedman and Bela Gorman who you'll hear from in our hour.

I also want to acknowledge Kim Davoncoch, she's been an expert who has worked with us for a

1 long time, a consultant on health care contracting
2 who has been very helpful to us including this
3 report and the work we have done in the Health
4 Care Division.

5 We do have a report that we will
6 distribute to any of you who want once we are done
7 but we hope you will listen to the presentation so
8 you can get the highlights of this as we go
9 forward, and I just want to say first of all, it's
10 my pleasure to be here, not only so we can make
11 our presentation but so that I can get educated
12 with all the great work that is going on in
13 Massachusetts and as far south as the Commonwealth
14 of Virginia.

15 So, we are presenting our results today
16 of our office's examination of health care costs
17 trends and cost drivers, that's pursuant to the,
18 what you have heard a lot about today, Chapter
19 118G, Section 6 1/2 B.

20 We know that the Commonwealth led the way
21 on access to health care and we believe that we
22 can lead the way in keeping health care
23 affordable. It's not going to be easy or quick,
24 you've heard that before and you'll hear it again,

1 and it's going to require the best thinking and
2 efforts of all of the parties in the system, the
3 not for profit, the for profit, government,
4 private sector but we think that these hearings
5 and we hope that our report can play an important
6 role in providing the information that will give
7 us the basis for critical policy discussions and
8 action thereafter.

9 The importance of this one issue, the
10 containing of health care costs cannot be
11 overstated. We're fortunate to have excellent
12 quality of health care here in Massachusetts and
13 excellent institutions who lead us in providing
14 for that health care.

15 They are the anchors of our community as
16 we've heard, they are employers and they are our
17 past and I believe and hope they will be the
18 future of Massachusetts, but employers here in
19 Massachusetts, whether they're big business, small
20 business, they are towns or cities, know that the
21 cost of health care is an issue that we cannot
22 continue to afford to ignore because we cannot
23 afford it.

24 We understand our progress is going to be

1 at risk, the progress we've made so far in access
2 if we find that health care costs get beyond the
3 reach of our employers and particularly of our
4 residents.

5 We have a unique opportunity that we're
6 going to try and highlight and this is the
7 equivalent of a pocket call, putting up the
8 conclusions here, so, these aren't related to my
9 comments at the moment, but the report that we're
10 going to highlight today has, I think gives us a
11 unique opportunity to address the information that
12 we uncovered through enormous amounts of work by
13 folks in our office and with help of some of you
14 in this room to provide a mirror of and a
15 transparency into a health care system.

16 We think that this information is unique
17 not just in Massachusetts but in the country. The
18 legislature has authorized us to do it and these
19 hearings I think are important because we must
20 diagnose what we need to correct.

21 We've taken our charge to the Attorney
22 General's Office seriously and we hope that this
23 health care report will identify in the health
24 care market an informational baseline as we strive

1 to control costs while maintaining access and
2 quality.

3 So, what did we set out to do in doing
4 this report. We wanted to look at cost drivers in
5 Massachusetts market and we first wanted to
6 understand how prices are established for health
7 care services.

8 At the outset of the review over a year
9 ago we were aware that the providers of health
10 care services were paid different prices by
11 insurers. What we did not understand well enough
12 before we started is how parties arrived at those
13 prices and what was the basis for disparate prices
14 paid for the same type of services.

15 First, the prices paid to providers are
16 the result of dozens even hundreds of discrete
17 negotiations. Each insurer negotiates with each
18 provider or provider network whether a large
19 academic hospital, whether it's a small community
20 hospital, a large physicians group or a small
21 practice and establishes a price paid for health
22 services.

23 The price typically for a particular
24 service, what we refer to as a unit price, but may

1 also be a capitated rate that is a price paid to
2 cover cost per patient.

3 Second, far more challenging than
4 establishing just what the price is paid was to
5 learn what drove those negotiations and what
6 ultimately explained the variations in prices
7 paid.

8 The analysis was both qualitative and
9 quantitative and we spoke to parties who
10 negotiated the contracts and we analyzed the data
11 that might help explain those disparate prices.

12 We considered conventional wisdom on why
13 health care prices might vary so materially, for
14 instance, whether it was difference in quality,
15 difference in the health of the patient
16 population, whether the provider served a large
17 Medicaid population which to some degree is
18 subsidized with private payments and whether it
19 was related to the costs of an academic medical
20 center.

21 We sought to evaluate the explanations
22 for disparate prices. Are the price differences
23 explained by high quality of care or the
24 complexity of service or the sickness of patients,

1 and as we will discuss very shortly we did not
2 find a correlation between different prices and
3 many of the things that we would expect like
4 better quality or sicker patients or teaching
5 hospital status.

6 What we did find is that market leverage,
7 the size of the organization, the various
8 strengths that it brings to those negotiations
9 with payers was the correlation to the price paid
10 and the conclusions from these findings should not
11 be in any way blaming of a particular player in
12 the health care system.

13 The more appropriate inquiry is what do
14 we do with this information now as we go forward,
15 what do we want to do about it and what can we do
16 about it and if we think that higher costs should
17 be explained for good reasons like better quality,
18 how can we make that type of incentive part of the
19 system, some of the same questions that Len
20 Nichols just asked very well before lunch.

21 If we think that high quality community
22 providers should not be at constant risk because
23 they may not match the negotiating levels of the
24 largest providers, how can the system reflect that

1 desire, and I am committed as I know my office is,
2 as I know many of you here in this room are here
3 today, including the Governor, the Senate
4 President, the house and the legislators who spoke
5 here this morning, we are committed to working
6 with the doctors, the hospitals, insurers, the
7 business community and all the other stake holders
8 to make sure that we get the right solutions as
9 quickly and practicable.

10 Before we move to a presentation on our
11 review and findings, I want to note that our
12 report does reflect a massive amount of
13 information we received from providers, all of
14 whom were incredibly cooperative with us and
15 provided the requested information and individuals
16 with whom we spoke.

17 That cooperation was essential to
18 fulfilling our mission to date and I believe that
19 cooperation will be there as we move forward to
20 seek some solutions to cost containment.

21 We will as I said at the close of our
22 presentation provide copies of the hearing, it's
23 also going to be on our web site, and I would just
24 note that if we have time, I know Commissioner

1 Morales has been very effective at keeping us to
2 time, I appreciate that, if we have time we would
3 be happy to answer questions, so, I would ask for
4 efficiency if you have questions, write them out,
5 we'll collect them and if we cannot get to them,
6 we'll make every effort to respond to you, so, if
7 you want to put your name and your own web site or
8 E-mail we'll try to respond to you after the
9 hearing.

10 I'm going to turn now the hearing over to
11 Assistant Attorney General Lois Johnson from our
12 Health Care Division. She's going to highlight
13 some of the key findings and she will be followed
14 by the experts with whom we worked to make sure
15 that our perspective and our work was as accurate
16 as possible, and so let me get off of this web
17 site so I'll let you get to where you want to be.

18 MS. JOHNSON: As the Attorney General
19 said, the results of our examination are detailed
20 in our written report which will be available
21 today both on our website as well as we expect the
22 Division of Health Care Finance and Policy website
23 and several copies will be available after our
24 presentation, but today I'm going to walk through

1 some slides that illustrate six of our seven key
2 findings.

3 Those findings that I'll talk about are
4 No. 1, like the Division's own analysis -- I'm
5 missing one flag here, I'm not sure why, No. 1,
6 like the Division found there are wide price
7 disparities across the Commonwealth in physician
8 rates as well as hospital rates, No. 2, that those
9 disparities are not explained by, as the Attorney
10 General said, expected value based factors like
11 quality or complexity, that 3, those disparate
12 pricings are explained by relative market
13 leverage.

14 No. 4, we found that payment methodology
15 does not correlate with variation and total
16 medical expenses, 5, now we're on the right slide,
17 those price increases, that price is a significant
18 cost driver of overall medical trend, and finally,
19 that 6, those higher priced providers are in fact
20 gaining market share at the expense of lower
21 priced providers.

22 The seventh finding regarding contracting
23 practices and provisions that reinforce and
24 perpetuate those market disparities are described

1 in detail in our report. Two of our experts will
2 follow with more detail on how we approached the
3 role of analyzing quality and price to arrive at
4 these findings, and as I said, these slides are
5 taken from our report in more detail and more
6 slides are found there.

7 So, first, our analysis showed that
8 payment rates for physicians and hospitals vary
9 significantly across the state and the results
10 aren't the same for each major carrier that we
11 looked at, so, it's not just with one particular
12 health plan.

13 This slide, for example, is a graphic
14 representation of the waterfall of comparative
15 payment rates among physician groups across the
16 state. For example, here it shows that there is a
17 90 percent differential from the lowest paid
18 physician group to the left to the highest paid
19 group to the right and that variation is the same
20 on the hospital side.

21 This next slide shows a similar waterfall
22 this time showing the variation in prices paid by
23 one particular insurer to hospitals in
24 Massachusetts and here we see a hundred percent

1 differential from the lowest paid hospital to the
2 left to the second highest paid hospital, and you
3 can see there's a significant variation from the
4 second to highest paid but from the lowest to the
5 second highest it's a hundred percent
6 differential.

7 So, what accounts for that variation in
8 payment to these providers who offer similar
9 services and often offer those services within the
10 same geographic area.

11 We looked, as the Attorney General said,
12 at a variety of factors, those factors most often
13 associated and cited to explain with differences
14 in rates to see if we can explain these
15 differentials.

16 For example, we looked at whether those
17 higher payment rates are tied to a proportion of
18 government patients that a hospital serves and we
19 found that they are not tied.

20 In this chart you'll see that the
21 hospitals with the higher mix of government versus
22 commercial patients known as disproportionate
23 share hospitals or to many in this room dish
24 hospitals, those hospitals are identified in red.

1 This chart shows that the dish hospitals
2 are not among the highest paid hospitals, they
3 would be clustered toward the right of the graph,
4 but instead tend to be among the lower paid
5 hospitals across the state.

6 In fact, our data shows that overall
7 commercial payments to dish hospitals are roughly
8 9 to 25 percent lower than commercial payments to
9 non dish hospitals. So, variation of rates is not
10 correlated to the high proportion of government
11 insured patients.

12 And a note here about quality, our
13 expert, Dr. John Freedman, will detail for you the
14 quality metrics we used and compare to price and
15 payment to arrive at our findings that there is no
16 correlation between prices paid and quality.

17 So, two other factors that we looked at,
18 teaching status and complexity of services. So,
19 one might assume and many have assumed that
20 teaching hospitals are more expensive than
21 community hospitals, that they get higher prices,
22 but we found that this is not always the case.

23 On this slide teaching hospitals are
24 identified in red. If all teaching hospitals were

1 among the highest paid hospitals in the state,
2 they would be clustered to the right side of the
3 graph. Again, here they're not. In fact, for
4 this particular health plan whose data you see on
5 the slide, of the top ten paid hospitals only two
6 are teaching hospitals.

7 So, another factor represented here is
8 sickness or complexity. We found that the
9 relative sickness or complexity of the patients
10 cared for by those hospitals or even on the
11 physician side, the health status of patients for
12 various physician groups do not correlate with
13 payment rates.

14 So, the yellow tape on this graph shows
15 case mix index or CMI for each hospital across the
16 state. The CMI which is calculated by the
17 Division of Health Care Finance and Policy shows
18 the relative complexity for patients treated at a
19 given hospital. A CMI of 1 is an average score,
20 hospitals with a higher CMI serve a more complex
21 or sicker population on average.

22 Of the top ten hospitals for this
23 particular payer, only two have CMI's above
24 average, so, we've seen that complexity doesn't

1 explain higher rates and we've done the same
2 analysis on the physician side and found no
3 correlation between higher rates of payment and
4 health status of the population treated.

5 So, we found that for the value based
6 factors as we're calling them of complexity,
7 quality, academic or dish status, there's no
8 correlation, no positive correlation with the
9 price.

10 We also found, and this is detailed in
11 our report and actually Bela Gorman will discuss
12 this in her remarks, that those high rates of
13 payment are not adequately explained by hospital
14 unit costs, the cost to the hospital performing
15 the services, so, where did we see a correlation,
16 what does explain the significant rate of
17 disparities that we see in the marketplace.

18 Well, one factor we found, one
19 significant factor is market leverage. Now, both
20 insurers and providers bring leverage into the
21 negotiations to result in payment rates.

22 Providers can have leverage based on
23 their size, their dominance in the insurer's
24 network, their geographic location, whether they

1 offer specialty services, whether they have a
2 brand name. So, we looked at market leverage in a
3 few different ways and one way was to focus on
4 that provider size.

5 Looking there, there are two measures of
6 size, one is revenue, the number of health plan
7 dollars going to a particular provider and second,
8 members or membership, the number of health plan
9 members associated with a provider or provider
10 system. So, using those metrics we found that
11 payment rates do in fact correlate with market
12 leverage.

13 This graph shows the comparative market
14 leverage among our major adult academic medical
15 centers, so, on this graph we illustrate the
16 relationship between the price the hospital gets
17 paid with higher prices going toward the right and
18 your size, here shown by revenue, with a greater
19 revenue going up to the top and the size of the
20 bubble, another factor, represents another aspect
21 of size, the members, the number of health plan
22 members associated with that particular hospital.

23 So, you can see in this graph that the
24 hospitals with the higher market leverage, they're

1 bigger and up higher on the graph are also plotted
2 furthest to the right on the graph because they're
3 also the most well paid.

4 So, it's important to note as
5 Dr. Freedman will discuss that quality does not
6 distinguish these providers but their respective
7 market leverage does.

8 And as we heard over and over in our
9 interviews with health plan players, provider size
10 whether looked at in terms of revenue or
11 membership is a significant factor in their rate
12 negotiations and there are of course other
13 important factors that contribute to market
14 leverage both on the provider side and the insurer
15 side and we discuss those in our report but this
16 slide shows the market leverage due to size.

17 Next we looked at another financial
18 metric that is useful to comparing providers.
19 Total Medical Expenses or TME tracks the per
20 member per month costs of delivery and care
21 associated with a particular physician group.

22 TME captures all costs, all spending and
23 accounts for both the price of the services and
24 the volume of services used, and our expert Bela

1 Gorman will describe it in more detail about the
2 metric of TME and its value, but when we compared
3 the TME of physician groups we found that the TME
4 does not correlate with payment methodology, that
5 is whether that physician group was paid on a fee
6 for service basis, here represented by the blue
7 bars, or a risk based basis, capitated or global
8 payment of some form, those are represented by the
9 red bars.

10 So, if there were a positive correlation
11 that one might expect with risk based payment type
12 arrangements you would see, you would expect that
13 the red identified physician groups would have
14 lower TME clustered towards the left of the graph,
15 but as this graph shows there is no correlation.

16 We see that some of the risk sharing
17 provider groups have among the highest total
18 medical expenses in the state. We showed that the
19 method of payment or how physicians get paid does
20 not predict whether or not they'll have lower or
21 higher medical expenses overall.

22 Next using the data that we gathered on
23 medical trend we can see the overall impact on
24 price and many have talked about the role of price

1 today and we want to highlight its importance.

2 The data from three large health plans
3 that we looked at show that the increasing prices
4 paid for services and not the increasing use of
5 services has been primarily responsible for the
6 increasing health care costs overall over the last
7 few years.

8 For example, this slide shows a breakdown
9 of the various factors that contributed to cost
10 growth from 2004 to 2008 for this particular
11 insurer and that's what we mean by medical trend,
12 those factors that contribute to cost overall.

13 Here you can see in blue that on average
14 over this period, 50 percent of the cost growth is
15 caused purely by price increases. An additional
16 20 percent we're told of this insurer's cost
17 growth is attributed to location or provider mix,
18 patients getting care in more expensive providers
19 and that factor is captured in the purple band.

20 The remaining 20, 25 percent of trend is
21 due to a combination of utilization and intensity,
22 the substitution of more intense services. So,
23 while utilization is important, it's a component
24 we found and I think is echoed in the Division's

1 findings that price is a far more significant cost
2 driver in Massachusetts, and Bela Gorman will give
3 some more details on medical trend analysis and
4 the role of price.

5 Finally, we looked further into the trend
6 of where patients are getting their services, the
7 provider mix and the effective price in
8 disparities.

9 As the last graph showed the change and
10 location of services from lower cost to more
11 expensive providers can have a significant impact
12 in overall cost growth. When we reviewed this
13 chart data, we found that lower cost hospitals are
14 losing volume to their high cost competitors even
15 when they offer comparable quality as we have
16 shown.

17 Our analysis shows and is represented on
18 this chart that hospitals who are paid above
19 average prices gained 2.88 percent in inpatient
20 volume over the past three years while hospitals
21 paid below average prices lost 1.15 percent in
22 inpatient volume during that same period, so,
23 we're seeing a shift.

24 The shift in market share from low cost

1 to expensive providers represents an overall cost
2 to the system, in the short term, the same health
3 care services are costing more, and in the
4 long term if the pricing trends we see continue,
5 lower paid providers will continue to lose volume
6 and be forced to close or we talked about mergers
7 with larger systems further exacerbating the
8 overall cost trends.

9 Before I turn the presentation over to
10 our experts, I just want to say a few words about
11 our examination. As the Attorney General said,
12 our review was extensive and thorough over the
13 course of a year plus we reviewed thousands of
14 documents.

15 Our team, especially Assistant Attorney
16 Generals Susan Brown and Karen Sung, reviewed
17 contracts, quality and price information, we also
18 used our unique statutory authority that the
19 legislature gave us in this examination to issue
20 CID's to fifteen providers, a range of community
21 providers, academic medical centers, dish
22 hospitals, physician organizations as well as to
23 the five major players in the state, but we didn't
24 just rely on documents, we also conducted dozens

1 and dozens of interviews with the market
2 participants and we asked them to help us verify
3 our data, to verify our analytical approach as
4 well as to verify our findings, and I just want to
5 say that our work wouldn't have been possible
6 without the cooperation of both the payers and
7 providers that we worked with, and on behalf of
8 our office and our team I just want to thank all
9 of those who assisted in pulling this information
10 together.

11 We're very pleased already that the
12 process has resulted in greater transparency and
13 disclosure of this important price and quality
14 information, and with that especially thanks goes
15 to our team of experts, two of whom will address
16 you today.

17 First, we have Dr. John Freedman who is
18 going to talk about the role of quality. Dr. John
19 Freedman is a physician, holds an MBA, he's an
20 expert in health care quality measurement who has
21 done extensive work with both providers, payers
22 and also governments.

23 DR. FREEDMAN: Thank you, Lois, and
24 good afternoon everyone. My name is John

1 Freedman, I provided expert consultation to the
2 Attorney General's Office in health care quality
3 measurement through the course of this
4 examination.

5 I'm a physician, board certified in
6 internal medicine and I've also earned an MBA. My
7 first formal position in quality measurement and
8 improvement was at Kaiser Permanente beginning in
9 1993.

10 Since then I've worked in a variety of
11 settings and I'm currently principal of Freedman
12 Health Care LLC, a firm that consults to
13 providers, payers, government entities and others
14 on issues of health care performance, performance
15 measurement and performance improvement.

16 We are fortunate that Massachusetts
17 boasts strong performance by many measures of
18 health care quality. For example, the National
19 Committee on Quality Assurance, NCQA, currently
20 ranks four Massachusetts commercial health plans
21 amongst the top twelve in the United States. The
22 2009 Commonwealth Fund report ranked health care
23 in Massachusetts as seven best in the country.

24 We're justifiably proud of the care

1 that's available here in Massachusetts, yet, we
2 also know that health care here is not better than
3 the national average on some measures and that
4 variation exists on some important aspects within
5 the state.

6 The Attorney General's examination did
7 not evaluate individual provider performance or
8 identify providers who performed better or worse
9 than others, rather, the Attorney General's
10 Office, which I will refer to as the AGO, examined
11 the role of quality in the current health care
12 system and in particular how commercial health
13 plans define and measure quality of care and how
14 they use quality information as they contract with
15 providers.

16 Through this examination the AGO obtained
17 extensive information on how Massachusetts health
18 plans rate the quality of providers. The AGO
19 examined to what extent the rate of quality of a
20 provider determined the level of pavements, in
21 other words, do health plans pay providers on the
22 basis of quality. The short answer to that
23 question is no.

24 I will briefly present the highlights of

1 the AGO's findings on quality, the validity of the
2 AGO's approach and the conclusions that I draw
3 from them. The AGO obtained and reviewed numerous
4 quality metrics that assessed the performance of
5 hospitals and physician groups, including dozens
6 of measures applied to physician groups and
7 hospitals over several years.

8 Some applied to nearly all providers,
9 some applied to subsets, such as hospitals
10 performing cardiac procedures or to over twenty of
11 the largest medical groups. By using the civil
12 investigative demands, the AGO obtained and
13 reviewed hospital and physician group information,
14 data and reports from the three largest health
15 plans in Massachusetts and from a cross-section of
16 provider organizations.

17 As part of the examination the AGO also
18 considered publicly available quality information
19 on hospital and physician groups. The information
20 produced by health plans shows that different
21 health plans use somewhat different quality
22 measures and aggregate quality measure information
23 in different ways.

24 While each health plan takes a unique

1 approach to evaluate provider quality, the major
2 plans generally select quality measures from
3 government and nonprofit organizations that are
4 widely used and accepted including the Center for
5 Medicare and Medicaid Services, CMS's, process of
6 care and patient experience measures, the Agency
7 for Health Care Research and Quality, AHRQ's
8 measures, NCQA's Health Care Effectiveness Data
9 and Information Set, HEDIS, and Massachusetts
10 Health Quality Partners, MHQP patient experience
11 measures as well as the Leapfrog Group Survey.

12 In examining the measures and methods
13 used by health plans or providers, the AGO did not
14 attempt to reach any conclusions regarding the
15 accuracy, statistical significance or
16 appropriateness of those measures and methods,
17 rather, the AGO considered the quality measures
18 that health plans track and report to examine
19 whether and how those measures influence contract
20 negotiations and to determine whether those
21 measures correlate positively to the prices paid
22 to health care provider, in other words, are
23 health plans paying more to providers who provide
24 higher quality care as measured by the health

1 plans themselves.

2 The AGO's review of quality information
3 was qualitatively and quantitatively valid.
4 Through its review of both publicly available
5 information and privately held information
6 produced in response to CID's, the AGO examination
7 was comprehensive in scope and appropriately
8 focused on the quality information and measures
9 that health plans and health providers themselves
10 are tracking.

11 Those measures are widely used and
12 accepted within the industry. Based on my review
13 of that extensive data collected by the AGO for
14 the period from 2004 to 2008 have several
15 opinions.

16 First, health plans and providers pay
17 attention to and generally care about providing
18 quality care and improving quality performance.
19 Next, the major plans generally select quality
20 measures from government and nonprofit
21 organizations that are widely used and accepted.

22 Despite some important variation,
23 Massachusetts hospitals and physician groups
24 perform well across most measures and are largely

1 clustered in a narrow to moderate range of
2 variability between them. For example, HEDIS
3 performance for twenty-six large groups was
4 clustered between a performance rate of 70 percent
5 to 80 percent from worst to best.

6 Put another way, the best HEDIS performer
7 was just 4 percent better than the average of the
8 groups. The patient experience scores were also
9 tightly clustered near the top end of the
10 performance range.

11 For cardiac procedures the state's
12 average mortality has fallen steadily and all
13 hospitals performing these procedures are
14 clustered closely together.

15 Last, the evidence shows that no provider
16 is consistently a top or bottom performer across
17 measures. There appear to be fewer measure
18 differences in quality from provider to provider
19 than would be suggested by popular opinion or
20 perception.

21 Comparing price to quality, with this
22 information collected the AGO examined whether the
23 significant pricing disparities it had found in
24 each major carrier's network could be explained by

1 differences in quality. To do this the AGO
2 compared the health plan quality data I just
3 described to price data using dozens of graphs and
4 comparisons to determine whether there was a
5 correlation between price paid and quality
6 measured.

7 These graphs include comparison of
8 physician and hospital prices and payments, excuse
9 me, prices and payments to the insurers own
10 quality and mortality scores for these providers
11 as well as the publicly available CMS process and
12 agent's hearing scores.

13 The AGO looked to see if what the market
14 players themselves use as measures of quality
15 drove their business in important ways such as
16 negotiating payments. For example, when a health
17 plan chooses a particular measure of quality to
18 valuing its provider network, the AGO examined
19 whether those same measures were correlated with
20 that plan's payments to providers.

21 If the market were indeed organized to
22 reward quality, we would expect to find a positive
23 association between a payer's quality rating for a
24 provider and the payment rate that the payer

1 negotiates with that provider.

2 The AGO's analysis shows that the wide
3 variations in price we documented are not
4 explained by differences in quality of care. The
5 AGO found no correlation between price and quality
6 and certainly not the positive correlation between
7 price and quality we would hope to see in a value
8 based health care market.

9 For example, the AGO examined the
10 relationship over three years between Blue Cross
11 and Blue Shield's payment rates and each
12 hospital's performance on the AHRQ measures which
13 Blue Cross Blue Shield uses to evaluate hospital
14 performance.

15 For that period of time the AGO found no
16 positive correlation between hospital performance
17 on AHRQ measures and their rate of payment. There
18 were many examples of higher performing hospitals
19 being paid less than lower performing ones.

20 There was no evidence that Blue Cross
21 Blue Shield paid hospitals based on how they
22 performed under the quality measures that Blue
23 Cross Blue Shield used to track hospital
24 performance.

1 Similar results were found with Harvard
2 Pilgrim and Tufts Health Plan data. Based on the
3 data provided by these health plans, the AGO found
4 that hospital payment disparities are clearly
5 unrelated to the quality of care as measured by
6 the plans and by CMS.

7 The examination showed the same results
8 on the physician side, for example, Tufts Health
9 Plan physician group data clearly showed no
10 relationship between quality and payment as well.

11 For Blue Cross Blue Shield there was a
12 moderate correlation between price and the HEDIS
13 measures used to assess physician groups and that
14 was the only example we found in the many
15 comparisons where there was at least some
16 correlation, but there was no correlation for Blue
17 Cross between its price and the results on patient
18 experience data either for children or for adults.

19 To summarize, for both hospitals and
20 physicians the AGO found no correlation between
21 payments by health plans and the measured quality
22 of care. In addition to thoroughly considering
23 quality information and data, the AGO also
24 examined senior physicians and quality experts

1 from the health plans and health providers who
2 concurred that there is no material difference in
3 measurable quality in Massachusetts hospitals or
4 physicians that would explain the price
5 differences in the market.

6 Conclusions, overall the quality of
7 Massachusetts providers is generally good.
8 Consumers should feel confident that the
9 Commonwealth offers many quality providers,
10 hospitals and physician groups all across the
11 state.

12 The differences in prices paid by the
13 major Massachusetts health plans were not
14 justified by demonstrable differences in quality.
15 The evidence points frankly to an inconsistency in
16 the market.

17 That is despite the apparent broad
18 acceptance that quality is critically important
19 and should drive the behavior of payers and
20 providers, in reality quality measurement plays
21 almost no role in the prices paid in the
22 Massachusetts health care marketplace.

23 I believe we must move towards a more
24 value based market where the quality delivered to

1 patients becomes a key driver of payment rates.
2 To get there the market be would benefit from 1,
3 movement to uniform standards for measuring
4 quality, 2, much more extensive public reporting
5 of quality and cost information, and 3, provider
6 contracts paying for quality to a degree far
7 beyond current practice.

8 Thank you very much for the opportunity
9 to present these findings, I hope to be able to
10 take some questions afterwards.

11 MS. JOHNSON: Now Bela Gorman, an
12 actuary and principal of Gorman Actuarial will
13 present. She's a fellow of the Society of
14 Actuaries and an experienced consultant to
15 government and the insurance industry.

16 MS. GORMAN: Thank you, Lois. Good
17 afternoon, my name is Bela Gorman and I'm a fellow
18 of the Society of Actuaries and a member of the
19 American Academy of Actuaries, and as Lois has
20 stated I've been a principal of Gorman Actuarial
21 over the past five years.

22 I have been assisting state governments
23 with analyzing the impact of health care reform
24 policies to the insured market. I've also

1 assisted various carriers in pricing and financial
2 forecasting.

3 Prior to that from 1999 to 2004 I was the
4 director of actuarial services at Harvard Pilgrim
5 Health Care responsible for pricing and financial
6 forecasting and I've held other actuarial and
7 underwriting positions with various insurance
8 carriers in Massachusetts.

9 I'm pleased to testify today about my
10 work on the AGO examination of health care cost
11 trends and cost drivers. As you've heard this
12 afternoon, the AGO found that the price increases
13 paid by health plans have a significant impact on
14 overall health cost trend.

15 I will focus my remarks today on the role
16 of price as a cost driver and will discuss the
17 financial measures the AGO used to analyze the
18 health care market and the importance of accurate
19 standard measures to track health care costs.

20 As part of this examination the AGO
21 reviewed four financial measures, pricing payment
22 relativity, total medical expense which I will
23 call TME, hospital unit cost and medical claims
24 trends.

1 So, the first financial measure I will
2 discuss is price and payment relativity. By using
3 civil investigative demands the AGO obtained
4 detailed information from the major health
5 insurance carriers on relative pricing for the
6 Massachusetts hospitals and affiliated physician
7 organizations in each plan's network.

8 The AGO reviewed relative pricing at the
9 aggregate rather than at the specific procedure
10 level. In other words, the AGO compared relative
11 pricing for all services a hospital would provide
12 rather than just one service.

13 I believe this approach more accurately
14 reflects the way health plans and providers
15 negotiate set price and resulted in valid
16 comparisons among providers.

17 The AGO obtained relative pricing
18 information in two different measures, price
19 relativities and payment relativities. These
20 different methods are both valid approaches in
21 comparing relative prices by health plans to
22 hospitals and physician groups and are well
23 accepted measures regularly used in the industry.

24 I do caution, however, that because the

1 relativities are carrier specific and use
2 different methods, the data should not be used to
3 compare a cross carrier or to determine whether
4 one health plan pays a provider more or less than
5 another health plan.

6 That said, the relativities of cross
7 carriers are directionally consistent and we
8 witnessed why price variations in each carrier's
9 network.

10 The next financial measure analyzed was
11 total medical expense or TME which is a measure
12 for physician groups. In simple terms TME is the
13 medical cost or spent per patient. Each health
14 plan calculates TME by summing annual member
15 medical expenses for physician organizations and
16 dividing it by total members present each month in
17 that year. Members are assigned to a physician
18 organization through their primary care physician.

19 TME includes all of the medical expenses
20 associated with a member regardless of where
21 services are rendered including physician visits,
22 hospital services, pharmacy, lab, behavioral
23 health and other services. TME reflects the
24 volume of services used by each member utilization

1 and the price paid for each service unit price.

2 The TME produced to the AGO by health
3 plans was health status adjusted to account for
4 the demographics and health status of the
5 population cared for by each provider system.

6 This enabled comparison of relative
7 spending per patient and insured that systems
8 caring for sicker populations will not
9 inaccurately appear as higher spending systems.

10 Since TME is health status adjusted and
11 includes all medical services it is a great
12 measure of efficiency. A lower TME will reflect
13 lower utilization and/or lower prices.

14 TME is the only financial measure that
15 reports on all services provided to a member and
16 boils it down to one number that can be compared
17 across physician groups. Through the AGO's
18 examination it was discovered that the health
19 carriers review this information but not routinely
20 given to providers so they can monitor their own
21 performance.

22 The AGO also received information that
23 some health plans and physician groups review MLR
24 as a measure of efficiency. MLR, or medical loss

1 ratio, is the ratio of total medical expense to
2 premium per member per month. In my opinion MLR
3 is not a true measure of efficiency because it is
4 not appropriate to compare physician group
5 spending to a premium where the premium is not
6 within the control of the physician group.

7 TME is a well accepted measure of cost
8 and efficiency that is regularly used in the
9 industry and I believe that public disclosure of
10 health care adjusted TME would help providers and
11 health plans to compare and address differences in
12 relative efficiency.

13 However, there are some issues to be
14 addressed. First, TME is more accurate for larger
15 populations where the average TME is less
16 susceptible to random increases or decreases that
17 could result in a small population.

18 Changes would need to be developed to
19 address this year to year volatility for TME for
20 smaller physician groups such as adjusting the TME
21 for large loss claims much like what we do for
22 small employer groups when setting premiums.

23 Second, TME is difficult to track for
24 products that do not have a primary care physician

1 requirement. One option is to explore the
2 possibility of developing attribution methods so
3 that we can track TME for non HMO products.

4 The AGO also reviewed hospital units
5 cost. Using publicly available data from the
6 Division of Health Care Finance and Policy, the
7 AGO calculated costs per case mix adjusted
8 admissions for each hospital in the state. This
9 is a widely accepted metric in the industry.

10 The AGO found variation in unit cost
11 across hospitals. There is limited information
12 available on hospital costs. Many hospitals do
13 not even have cost accounting systems.

14 Moreover, the 403 data that DHCFP gathers
15 each year is not used meaningfully by the
16 hospitals. I believe that better analysis can be
17 performed if standard hospital unit cost
18 information were measured and publicly reported.

19 In order to understand cost growth the
20 AGO examined the underlying factors that
21 contribute to overall increases in health costs by
22 reviewing medical trend data. All three health
23 plans provided medical trend data and the AGO
24 considered and relied on the industry analyses.

1 Trend analysis is a key function for any
2 pricing actuary and it is routinely performed to
3 ensure that premiums are set appropriately. The
4 major components of medical trend are utilization,
5 unit price, mix of services and provider mix.

6 The unit price component is the trend in
7 the pure price of a service. Utilization is the
8 trend in the number of services being provided,
9 for example, if more office visits are being
10 provided this would be a utilization trend.

11 Utilization trend will reflect the aging
12 of a population and change in the health status of
13 a population. Mix of services is a component of
14 trend where the intensity of services being
15 provided is increasing, and finally, provider mix
16 represents a shift of services from lower cost
17 settings to higher cost settings.

18 Health plans track and report the
19 components of trends differently. While there are
20 some differences, data from the three largest
21 health plans show that unit price increases are a
22 major contributor of increases in medical trends
23 in the Massachusetts health marketplace over the
24 last few years.

1 For some health plans the information
2 produced shows that price contributes as much as
3 70 to 90 percent to medical trends for those plans
4 over the past few years.

5 Another plan shows price contributing
6 over 50 percent to medical trend while change in
7 provider mix contributes approximately 20 percent
8 to overall cost growth.

9 I believe that these findings are
10 consistent with the conclusion in its preliminary
11 report that price increases were the major driver
12 of growth in spending for most health care
13 services.

14 In my opinion, price is a significant
15 driver of cost trend and needs to be addressed in
16 any policy solution designed to contain health
17 care cost growth. Efforts to address utilization
18 are important but unless price trends are
19 mitigated, cost containment efforts will not have
20 meaningful impact on overall trends.

21 The AGO also reviewed hospital discharge
22 data for adults from 2005 through 2008 and found
23 that more expensive providers are gaining volume
24 while less expensive providers are losing volume.

1 This is the provider mix component of trend. As
2 hospitals with higher prices attract more
3 patients, overall health care costs go up because
4 patients are receiving the same service at a
5 higher price.

6 It is my opinion that as market share or
7 footprints increased for more expensive providers,
8 cost to the health care system increased overall.
9 This impacted medical trend and premium.

10 In closing, I would like to highlight the
11 importance of accurate and reliable data to
12 compare and track health care costs and delivery.
13 The AGO received a wealth of information from the
14 major health plans in the state.

15 I know it was a huge undertaking to pull
16 all this information together. I commend the
17 health plans for providing this information. I
18 think we can use the price and payment data and
19 other information to develop appropriate cost
20 containment solutions.

21 The AGO's analysis was valid and
22 reasonably relied on the financial information
23 produced by health plans and health providers.
24 Based on the AGO's analysis and my own experience,

1 I believe that the system now maintains accurate
2 and reliable information on price, payment and
3 total medical expenses that should be considered
4 to compare cost and delivery system efficiency.

5 Based on the AGO's analysis and my own
6 experience I believe that the public reporting of
7 hospital unit cost information should be improved
8 and standardized to allow better comparison of
9 hospital cost information. Thank you.

10 MS. COAKLEY: Thank you, Lois and
11 Dr. Freedman and Bela for that information. We do
12 have reports, I know it's a lot of dense
13 information and I know it was hard to see some of
14 those small names up there, but it's all in the
15 report that will be available either copies here
16 or on our web site. Very quickly in conclusion we
17 have a couple of questions, and David, give me the
18 elbow to sit down.

19 MR. MORALES: Yes.

20 MS. COAKLEY: We believe that these
21 findings are crucial as a starting point at this
22 stage to start to talk about where we go next in
23 terms of cost containment solutions but we believe
24 that we can develop those solutions.

1 I think there is excellent news in these
2 reports on quality and the quality of health care
3 in Massachusetts. I think that it is a positive
4 launching point.

5 As I said earlier, to go forward noting
6 that we provided for access, we have quality, we
7 just need to figure out the cost of these and it
8 is, this information is critical to include in the
9 marketplace.

10 I think that we found that metrics like
11 using the total medical expenses can be used to
12 track provider efficiency which is going to be one
13 of the things we need to look at and that further
14 uniform quality metrics will help employers and
15 consumers to choose benefit designs and providers
16 in a way that they haven't had that option before,
17 it's an important step forward.

18 I want to make it clear that this report
19 does not point to a single or simple solutions.
20 Indeed, we're not really focusing on solutions in
21 this report yet.

22 We think that again, this is not going to
23 be easy to do but we believe that we have some
24 policy recommendations going forward that I think

1 can help us provide some solutions.

2 Based upon our review and analysis the
3 following recommendations we think will promote
4 the goals of I think everybody in this room and
5 everybody in this Commonwealth wants to achieve,
6 that we encourage a transparency of price and
7 quality information and provide for future
8 standardization of price and quality measurements
9 to give consumers, both the individual consumers
10 and employers who are purchasing this in ways to
11 start to measure what they're buying.

12 We need to mitigate market disfunction
13 and promote prices that will better correlate to
14 value such as higher quality of more complex
15 services required. We want to promote prudent
16 purchasing through insurance product design,
17 decision making tools and education of consumers,
18 and finally, we want to work to reform contracting
19 practices that reinforce and perpetuate some of
20 the disparities that we've outlined in the current
21 market and create the market disfunction.

22 For example, and this is explained
23 further in the report, parity provisions,
24 supplemental payments, restricting provider

1 participation clauses and unfair use of growth
2 caps, all of which we believe do not enhance
3 either a transparent market or the ability of the
4 consumer to make good decisions.

5 As I said earlier, we look forward to
6 working with you, Commissioner Morales, with the
7 legislature, with the Patrick administration, with
8 our health care providers, hospitals, businesses,
9 municipalities, consumers in making sure that we
10 move forward in cost containment and continue to
11 provide for access and quality.

12 I do have two quick questions here, one
13 is not so quick a question but has a quick answer
14 for me, Len, in order to create countervailing
15 market power, Len Nichols suggested payers
16 collaborate in a variety of ways including sharing
17 payment information and incentives.

18 He said this would require both creative
19 state antitrust people, unquote. Would your
20 office be willing to work with health plans to
21 identify areas where collaboration rather than
22 competition would be more effective in controlling
23 medical costs and then structuring ways to
24 encourage them to allow that collaboration.

1 The short answer of course is yes, so,
2 that's the shortest answer you'll ever get from me
3 probably, but I will say that these issues around
4 antitrust and collaboration have come up as we
5 worked with Dr. Bigby and we will continue to put
6 our efforts into that because we think it is an
7 important place to go, so, I appreciate that
8 question.

9 The second question is what legal tools
10 does the AG have to correct this problem outlined
11 in our presentation. The short answer is I'm not
12 going to answer that now, so, that's a quick
13 answer, but part of what we wanted to do as we've
14 gone through this is take this in the logical
15 steps which is make sure that we have this
16 information right as when we issued our
17 preliminary report, and with this report we
18 welcome criticism of it or concerns or issues that
19 you may have with it.

20 If we agree going forward that it is the
21 proper at least outline for the slides that we
22 looked at, that it's correct and accurate in that
23 respect, then we will now refer back to this
24 question, look at what tools we have in our

1 arsenal but some may have to come from the
2 legislature and some may require regulation, but I
3 think our first step is to make sure we have this
4 right and see what goals we have going forward and
5 what we can accomplish with everybody at the table
6 and we are committed to making that happen.

7 So, unless there are any other questions,
8 we have probably one or two more minutes. Seeing
9 none, I want to thank our panel again for the
10 enormous amount of work that our office did and
11 for our experts and thank you.

12 (The audience applauded.)

13 MR. MORALES: Thank you, Attorney
14 General Coakley. A very, very, very helpful and
15 useful presentation. At this time I'd like to
16 call to the podium and to the panel Wayne Burton,
17 the president of North Shore Community College
18 will who will moderate the employer panel.

19 I'd also like to call to the head table
20 Michael Widmer from the Mass. Taxpayers
21 Foundation, Delia Vetter from EMC Corporation,
22 Frank Romano, Essex Management Group, Peter
23 Mongeau, I'm probably getting that wrong, Peter,
24 from Hancock Financial Services, Eric Michelson of

1 Michelson's Shoes, and Alan MacDonald from the
2 Business Roundtable.

3 I look forward to a robust discussion
4 now, not only to hear from the employers about
5 what they're experiencing relative to health care
6 costs but also some of the issues that and
7 initiatives they have undertaken to address some
8 of those health care cost increases, so, Wayne,
9 thank you.

10 MR. BURTON: Thank you, Commissioner
11 Morales, it's a pleasure to be here. I am Wayne
12 Burton, I am the chair of the North Shore Chamber
13 the past two years.

14 The North Shore Chamber is the third
15 largest in the state with over 1,600 members, and
16 I can tell you to set the stage that all 1,600
17 told me last year that the cost of health care is
18 the most significant inhibitor in business
19 recovery and expansion that they face.

20 I also want to thank Governor Patrick for
21 meeting with the heads of all the chambers
22 frequently on this issue, Representative Stanley,
23 the Chairman of the Committee for her interest,
24 and every night I kneel beside my bed and say I

1 have 700 employees employed by GIC which pays
2 \$12,000, half of what small business pay for their
3 insurance.

4 I will ask the panel to speak clearly for
5 our stenographer today, she is taking verbatim
6 testimony. What we're going to do is after
7 presentations, I'm going to ask some questions of
8 the panel, we'll take some questions from the
9 audience but they're going to be in writing to the
10 staff.

11 With that, it's my pleasure to introduce
12 Peter Mongeau, vice president HR Shared Services
13 John Hancock Financial Services, Peter.

14 MR. MONGEAU: Thank you, my name is
15 Peter Mongeau, I'm vice president of human
16 resources for John Hancock Financial Services and
17 I'm responsible for our employee compensation and
18 benefit programs.

19 John Hancock is a financial services
20 company with approximately 5,500 employees
21 nationally and 4,000 employees in Massachusetts.
22 Our projected 2010 medical plans spent for our
23 current employees including employee cost sharing
24 is approximately 47 million dollars of which more

1 than 70 percent or roughly 33 million dollars is
2 spent in Massachusetts.

3 We manage another 50 million dollars for
4 retiring medical benefits. Our medical plan
5 increases on a weighted average basis have been in
6 the roughly 6 percent range for the past two
7 years.

8 On a relative basis, this is better than
9 certain benchmarks; however, this rate of increase
10 is greater than most of our other operating costs
11 making it not acceptable in the long term to our
12 policyholders or shareholders.

13 We attribute our results to two
14 overarching strategies, one, collaboration and
15 partnership with our health plans to invest in and
16 improve workforce health and productivity.

17 Two, treatment and engagement of our
18 employees as consumers where choice and buyer
19 information or transparency is important given the
20 diversity of our workforce. I'd like to share
21 with you an example of each strategy.

22 We have had what is referred to as a sole
23 source partnership with Harvard Pilgrim Health
24 Care for the past seven years. Our approach is

1 that John Hancock and Harvard Pilgrim team up to
2 pilot health and productivity initiatives and to
3 capitalize on those that produce results that then
4 John Hancock continues to leverage and Harvard
5 Pilgrim has the option to integrate into an
6 overall product offering.

7 One successful pilot and continued
8 investment we make is in our healthy insurance
9 program, which is a cardiovascular risk reduction
10 assessment and counseling service. Healthy
11 returns has garnered medical savings of \$110 per
12 participating member per year.

13 These results have come from high
14 expectations and high performance on the part of
15 both John Hancock and Harvard Pilgrim and most
16 notably not through hammering away at rate
17 increases during annual renewals.

18 Collaboration by health care stakeholders
19 works and helps to get at drivers of health care
20 costs. With respect to seeing our employees as
21 consumers, this helps to ensure we offer
22 meaningful choices in levels of coverage where
23 employees own and quite frankly pay for their
24 decisions.

1 For example, if employees choose
2 nongeneric prescription drugs, they pay 20 percent
3 coinsurance of the drug's price versus a copayment
4 which caps their expenses. John Hancock was
5 willing to adopt coinsurance for nongeneric
6 prescription drugs as are only 20 percent of other
7 Massachusetts employers because information is
8 readily available on drug efficacy and the dialog
9 about drug options is one that is less complex for
10 employee consumers to have with their physicians
11 and pharmacists.

12 We intend to continue on this path but we
13 will pace ourselves based on the availability and
14 usefulness of sound and trusted health care
15 consumer information and pricing transparency.

16 Choice is key to driving cost savings.
17 We do not seek to limit options, only to have
18 employees be educated consumers and accountable
19 for their health care consumer decisions.

20 With that we think market forces will
21 come to bear where improved value and lower cost
22 is sought which will help drive efficiencies and
23 improve health care outcomes.

24 On behalf of John Hancock I appreciate

1 this opportunity to share some of our experiences
2 in managing our challenging health care costs,
3 thank you.

4 MR. BURTON: Thank you. Next up Eric
5 Michelson of Michelson's Shoes, Eric.

6 MR. MICHELSON: Thank you, I'm Eric
7 Michelson of Michelson's Shoes, and we operate two
8 full service family shoe stores in Lexington
9 center and Needham center.

10 We employ twenty-four people ages
11 seventeen to eighty-seven, many of them have been
12 with us for over ten years, some for over thirty
13 and in return for that loyalty and dedication we
14 pay a hundred percent of our employee's health
15 insurance premiums.

16 We have two problems with health
17 insurance, our premiums are huge compared to
18 larger organizations and our annual renewal
19 increases are staggering. We've been quoted a
20 33 percent increase in our April 2010 renewal.
21 When that occurs our premiums will have risen over
22 75 percent since 2004 and our insured annual
23 out-of-pocket costs substantially increased also.

24 Currently twenty-one of my twenty-four

1 employees are eligible for coverage, we cover
2 fourteen of them and the average age of our group
3 is fifty-eight and a half years. Our insurance is
4 a Blue Cross product called HMO Blue Deductible,
5 which is a \$500 individual, \$1,000 family
6 deductible. Prior to that we used a traditional
7 HMO product and paid a hundred percent of the
8 premiums.

9 In April 2009 we switched to a deductible
10 product because of better rates and we continued
11 our commitment to our loyal staff by funding a
12 hundred percent of the deductible. Annual
13 premiums for a family plan is currently \$19,618
14 and will rise to \$26,080.

15 Now a comparison, a forty-nine-year-old
16 person can purchase an identical Blue Cross plan
17 directly for \$20,436. In addition, I have
18 experience as serving on the Town of Lexington's
19 Corporation Committee and one of our areas of
20 research has been health insurance costs, and I'm
21 comparing 2008 rates here but our business rates
22 in that year were \$23,210 for a family plan while
23 the Town of Lexington covered the same family
24 plan, same type of coverage for \$17,441 and the

1 state GIC was at 13,584.

2 My rates also have to be looked at in
3 cost per hour per employee basis. Since the
4 majority of our employees are couples on family
5 plans, the deductibles and premium costs for us
6 run from \$8, \$8.58 an hour to \$13.02 an hour,
7 that's on top of the salaries, an additional 12 to
8 42 percent increase in compensation.

9 This obviously will hinder my ability to
10 hire new employees. I'm forced to make offers to
11 new hires based upon total compensation and
12 offering lower salaries in order to offset these
13 premiums. My best offers remain thousands of
14 dollars less in salaries than you get from a major
15 chain store.

16 Finding more affordable coverage consumes
17 dozens of hours that could be better used by
18 running our business. We even looked into
19 products offered through the Connector, but their
20 improved pricing masks the highly limited networks
21 these plans use.

22 We have also used every tactic possible.
23 We have changed carriers to get new customer
24 incentives, we've increased copays and we've gone

1 to deductible plans. Mass Health Care Reform
2 enacted in 2006 was supposed to favorably affect
3 rates due to universal enrollment but instead of
4 premium relief, we saw in 2008 renewal rates jump
5 25 percent and we had thought that we had seen the
6 worst.

7 Last year the industry saw a deductible
8 policy designed to save money by making consumers
9 out of all of us. While we saved money in year
10 one, year two brings on premium increases that
11 total more than the salary of another employee.

12 I'm unable in this economic environment
13 to even begin to comprehend how I'm supposed to
14 absorb this cost to my business.

15 There are at least two bills working
16 their way to the State House, House 4452 seeks to
17 create an affordable health care plan and that is
18 ultimately its downside.

19 The legislation favored by the health
20 insurers create only one affordable option, a low
21 premium, high out-of-pocket broad type plan that
22 is inappropriate for middle to older age people, a
23 plan I would not want my family or my employees to
24 have.

1 House 3452 and Senate 446 takes a more
2 effective approach to obtaining relief by allowing
3 small businesses to join together to purchase
4 insurance from a larger group, GIC styled
5 insurance for small businesses that would offer
6 multiple options, level the playing field between
7 large corporations and small businesses.

8 It costs no more for the insurance
9 company to pay for my employee to receive health
10 care than an employee in a large corporation or a
11 city or state employee or retiree, yet my
12 employees are suffering because I lack the buying
13 power to get them a fair deal.

14 In order to remain competitive and become
15 the edge that drives the state's economic
16 recovery, small businesses need across the board
17 equity. Once our costs are the same as those
18 large employers, a way has to be found to control
19 and justify the double digit increases in annual
20 premiums which is becoming the norm and not the
21 exception, thank you.

22 MR. BURTON: Thank you. Next is
23 Michael Widmer, president of the Massachusetts
24 Taxpayers Foundation, Michael.

1 MR. WIDMER: Thank you, thank you for
2 inviting me. As president of Massachusetts
3 Taxpayers Foundation since 1992 I've been involved
4 in a wide range of health care issues in
5 Massachusetts, before that actually I was head of
6 human resources for a major corporation in which
7 obviously one of my responsibilities was health
8 care.

9 I want to issue, or not issue, comment on
10 with a voice of caution. I absolutely agree that
11 there is a cost to inaction in the Commonwealth in
12 terms of the escalating cost of health care, at
13 the same time there clearly is a cost to misguided
14 and precipitous action, so, I think the collective
15 responsibility we have is to steer our way through
16 those two polls.

17 Let me touch on three points that were in
18 the, of all of the fantastic work done here by the
19 Division, but first to underscore the obvious, the
20 very first paragraph, health care is the state's
21 top industry, the largest employer, Commonwealth
22 Fund ranks Massachusetts first in terms of access
23 to care, seventh overall in the state score card,
24 Massachusetts hospitals are often cited as among

1 the best in the nation in terms of quality and
2 health care services provided, Massachusetts
3 health insurers are consistently rated among the
4 top ten best plans in each category nationwide, we
5 all know that but it's not guaranteed so I just
6 wanted to mention that first.

7 Secondly, a very interesting statistic
8 here on page 7, namely that comparing
9 Massachusetts to other states on per capita health
10 spent as a percent of gross state product,
11 Commonwealth ranks near the middle, 13.3 percent,
12 interesting, near the middle and that adjusts for
13 the wealth of the population which is I think a
14 fair measurement.

15 Again, not to say we don't have a problem
16 on health cost but I think that is an important
17 fact. Thirdly, if we look at the most recent
18 data, and this has probably changed since but I
19 think it's nonetheless important, from 2007 to
20 2008 the adjusted growth in small group premiums
21 grew 5.8 percent, midsize 4.8, large group 5.4,
22 yes, a larger increase for the small group market
23 but not a dramatically larger increase. Again,
24 those are I think factors that one needs to keep

1 in mind.

2 Let's look at the legislation and the
3 potential legislative action in 2010, particularly
4 focused on the area of small business and I agree,
5 we do need to do something but again a balance.
6 There are a number of options, a previous speaker
7 already talked about some of them, but ideas about
8 limited network, offering, requiring small
9 businesses to have a limited network option, a
10 semiannual enrollment period, the moratorium on
11 the enactment of new mandates, these and other
12 areas I think conform the core of legislation this
13 year that will be helpful to small businesses in
14 the short term, at the same time not have the kind
15 of unfortunate unintended consequences of some
16 other proposals.

17 I'm particularly concerned about the
18 proposal from the Governor to have a cap on
19 insurance premiums effective April 1. I don't
20 think price controls over the years have been
21 shown to be effective in addressing the underlying
22 system and problems.

23 This is a particularly onerous version of
24 that to jump into the market at this late date and

1 to establish arbitrary premium caps, I think you
2 will have all sorts of unintended negative
3 consequences, exacerbate many of the problems and
4 not deal with the underlying causes.

5 Two final comments, one is one of the
6 problems we have here that needs to be addressed
7 or at least raised and that is through every
8 fiscal crisis, one of the ways we deal with a
9 Medicaid problem because it's such a large part of
10 the state budget and it grows as health care costs
11 grow of course is that we cut payments to
12 providers.

13 So, we have done that two, three, four
14 times already and this will continue I will
15 predict in the ongoing fiscal crisis which lasts
16 at least through fiscal 2012, so, therefore, we're
17 underpaying providers for the cost of public care
18 that we ask them to provide.

19 That obviously puts pressure on the
20 private side. Now, it's not one to one, there's a
21 delay, but nonetheless one of the issues we need
22 to collectively face is if we underpay on the
23 public side, there is a consequence to the private
24 side.

1 Finally, I'll close on a separate issue
2 but absolutely critical and that is the soaring
3 cost of municipal health care which is priced from
4 municipal finances and it's been seen in that
5 context, but I would urge us selectively to see
6 that problem in the context of escalating health
7 care costs for a major fraction of our population.

8 There are tens of thousands of local
9 employees and retirees that are seeing huge
10 increases year to year largely because it's
11 impossible for local officials through the
12 collective bargaining process to manage those
13 costs.

14 One simple proposal which we strongly
15 favor is to take the powers, give the local
16 officials the powers of our health plan design
17 outside of collective bargaining, the same powers
18 the GIC enjoys for state employees and retirees.

19 We have documented that that would save
20 an enormous sum for municipalities and would help
21 bring down the overall rate of health care costs
22 in the Commonwealth, thank you.

23 MR. BURTON: Thank you. Next Frank
24 Romano, chief executive officer of Essex Health

1 Care, Frank.

2 MR. ROMANO: Thank you, I'll leave my
3 testimony for you and just have a few comments off
4 the cuff if I could. The first thing I want to
5 tell you is I'm not an expert, so, I am nothing
6 but an entrepreneur that started a company
7 thirty-seven years ago after leaving IBM and we
8 provide health care to seniors in Massachusetts.

9 I'm not sure that we're going to make the
10 next five years if we cannot do something about
11 increasing health care costs for our employees.
12 That is clearly the struggle we're dealing with
13 and I certainly empathize with my colleague to my
14 left in trying to find affordable health care.

15 It's amazing to me that some of the
16 issues that I see that we now have 97 percent of
17 our employees insured, which is just wonderful,
18 the trouble is we became self-insured three years
19 ago in an attempt to reduce our costs from
20 twenty-five years of Blue Cross Blue Shield and
21 for a while things were looking good and then all
22 of a sudden this last year our premiums went up
23 25 percent, so, we began to sit down and say what
24 is going wrong with our numbers, where are we off.

1 Well, we found out that we exceed visits
2 to the ER, our employees do by 50 percent over the
3 national average. Now, we came to the simple
4 conclusion that there's just not enough primary
5 care physicians in Massachusetts with panels that
6 are open to take our employees, so, they still go
7 to the ER because now they have insurance.

8 We changed that this year by changing the
9 deductible. We made it more expensive to go to
10 ER, much less expensive to go to the doctor and an
11 urgent care center, but it seems to me that the
12 paraprofessionals, the nurse practitioners would
13 move a long way to having access points to health
14 care in Massachusetts, and there was a recent
15 article, and I have copies for you, it says nurses
16 covering more health care, it's about several
17 states that allow practitioners to actually write
18 scripts, and I'm sure you're all aware of this,
19 but I think the nurse practitioner option to help
20 physicians would be a great way to reduce the ER
21 visits.

22 The other concern we have 50 percent of
23 all our female employees did not get mammograms
24 even though we paid for it, so, I began to study

1 our numbers and I've come to the final conclusion
2 we have to get more employee responsibility for
3 the health care and to that I looked at life
4 insurance policies. If you're overweight, you pay
5 a premium, if you smoke, you pay a bigger premium,
6 if you ride a motorcycle, you pay another premium,
7 so, it seems to me until we get our employees
8 actively involved in the cost of health care,
9 we're not going to get this ship turned around.

10 So, I absolutely know right now today if
11 you're a smoker and smoke one pack a day, at about
12 8.50 a pack, it's \$3,100 a year, it's a lot of
13 money, and I think the issue that we have to look
14 at is how do we motivate them, and the only way I
15 know how to do it at this point is if you're
16 spending more money out of your own pocket for
17 your insurance, hopefully you'll begin to look at
18 stop smoking, taking our cessation program, going
19 on some of the meds that do help you break the
20 habit, but this is what we feel has to happen.

21 And then lastly, we have been working on
22 an innovative program at a local hospital and our
23 building in Milford, Massachusetts, all of our
24 employees would go to the local hospital at a

1 capitated rate. We would bypass, we use Harvard
2 Pilgrim now as a TPA, we would bypass Harvard
3 Pilgrim now and go direct.

4 All our employees have to use Milford
5 Hospital, have to use their medical group and all
6 the care would be provided by them and I would pay
7 the hospital so much per month, but certainly that
8 takes one more cost level out of what a TPA
9 charges us to manage our care.

10 The trouble is convincing the hospital
11 they won't get beat up in the capitative rate, and
12 I've suggested we consider a reinsurance policy
13 and assess it every year but then we're both in
14 the same trap, they are trying to keep the cost
15 down, we're trying to keep the cost down, but
16 we're at that point.

17 I mean we are desperate trying to find
18 solutions to where we are and especially from
19 affordability and our employees can't take another
20 hit. We can't go back to them next year and tell
21 them it's another 24 percent increase even though
22 we pay for a major portion of health insurance,
23 that 24 percent to them is a large number. Thank
24 you.

1 MR. BURTON: Thank you, Frank. Alan
2 MacDonald, executive director of the Massachusetts
3 Business Roundtable.

4 MR. MacDONALD: Thank you. Cost
5 trends from the employer point of view, in the
6 earliest days when we got employers fairly
7 involved, there's so much change in our lifetime,
8 certainly in my lifetime, it was not expensive to
9 employers necessarily in the 1950's and 60's.

10 It really was only 4 percent or so of the
11 gross domestic product that might have grown to
12 7 percent by the end of the 60's, but it was
13 passed through to the consumers, and we had a very
14 strong U.S. economy at that time buying a lot of
15 U.S. products in the 1970's, and I say this having
16 worked for GE during the 70's and through the
17 80's, we saw a tremendous change in the economy
18 where the costs were not passed through to the
19 consumer because the consumer was buying Sweden,
20 Korea, Japan, the world, and at that time we
21 started on the employer side to get very concerned
22 about the increases that we saw as the percentage
23 of the GDP grew to the point that it more than
24 doubled to where it was by the end of the 60's by

1 the end of the century.

2 So, in the 1980's that's when the
3 employers in my experience really got tuned in to
4 trying to manage the cost trend which as we know
5 is continuing, and to the earlier comments in a
6 2006 report we did at the Roundtable, we saw the
7 average family of four health insurance policy to
8 be over \$12,000 in 2005, which at that time was
9 about 13 plus percent of the median income in
10 Massachusetts which is a high income, but the
11 median income at that time was \$90,000 which is a
12 very high income but here was our health care
13 being 13 percent for the average family of four
14 contract.

15 10 percent increases per year would get
16 that 20, 15 to \$31,000 plus for the average health
17 care contract which would be even if we had
18 4 percent growth of income which we are not having
19 would be over 25 percent of the median income in
20 Massachusetts.

21 That's the trend line we see, so, what
22 were employers trying to do in the 80's and into
23 the 90's, it was managed care contracts. We found
24 that it was very successful to define a set group

1 of providers and a set group of covered lives and
2 predict ahead of time actuarially what the
3 likelihood of how many mammograms, how many
4 procedures would be done and pay upfront, very
5 similar to the discussion now about global
6 payment.

7 That wasn't universally popular as we
8 know and didn't pan out for the reason that even
9 employers in helping employees push out of network
10 did go out of network and that caused us not to be
11 aware of what the cost per procedure would be
12 because we couldn't guarantee any certain number
13 of procedures. That was an effort that was tried
14 and not successful for the long term.

15 So, into the start of this decade we got
16 much more into consumer directed health plans. I
17 should say that part of what we tried in the 80's
18 was changing insurers. We would change, employers
19 would every couple of years another insurer and it
20 gave us one or two years of savings versus the
21 prior year but it was not a long term solution.

22 Looking for the long term solution we
23 liked the managed care, that didn't stick, so, we
24 have gone to what you just heard and will hear

1 more of is the consumer directed health plans,
2 which work, really work to convince, to get the
3 employer employee relationship involved in a
4 market related relationship so that the consumer,
5 the employee would not have unnecessary health
6 costs, avoidable health costs, inappropriate
7 health costs.

8 When we say unnecessary, we mean those
9 that haven't proven to be of value necessarily but
10 a desire by the consumer because there isn't any
11 economic impact to make that choice, but there
12 would be a medical impact that would say if there
13 is no value, you shouldn't necessarily have to
14 make that choice, avoidable by using wellness
15 programs or case management.

16 We found when we researched what helped
17 us the most at the start of this decade was good
18 case management of chronic illness so that people
19 who were the most dependent on the health care
20 system could manage their diseases the best and
21 that had economic positive impact as well as
22 health impact.

23 Inappropriate to us would be the wrong
24 settings, a setting that didn't necessarily fit

1 the procedure that's necessary or desired by the
2 employee consumer.

3 So, those three things are very important
4 in consumer directed health plans to involve the
5 consumer, the employee in an awareness of the
6 economic impact of the system and the correct use
7 of the system.

8 So, that was a big move for us and we
9 have found as we were asked to testify today what
10 is most successful, and it's those kinds of
11 approaches and it is true that a managed care
12 approach economically is a very successful
13 approach for us and if it relates to the global
14 payments of circumstances that we're dealing more
15 of today, that may be something that we would find
16 to be very helpful.

17 We did over the years see the utilization
18 of the system did cause us to see cost trends go
19 up, we did see that the technology in the system
20 did cause us to see the costs go up, but again,
21 with the right consumer directed health plans we
22 have found that that has helped us out in some
23 control of the cost growth, some management of
24 cost growth.

1 I would just say to what Mike Widmer
2 said, and I'll close with this, that that part of
3 the cost trend to us is consumer behavior in a
4 positive or negative way, the system has caused us
5 to look at the trends as we've seen the trend in
6 the health care system grow as supply and demand
7 have both grown together over time, the system has
8 grown in subsidies of both private and public to
9 be a very expensive system where we try to do as
10 much as we can to each and every patient.

11 The difficulty as we've seen with the
12 inability of the public pay to support the system
13 because now the public pay as we know is more than
14 half of the dollars into the system.

15 We've built a very expensive system,
16 we're now trying to support it with Medicaid,
17 Medicare dollars and very difficult to do and
18 since we can't do it frankly in a very difficult
19 economic time, we need to lean on the private side
20 more to support the whole system.

21 So, it does require as we look at that
22 trend for an ability for all parties to work
23 together to see what we can do about redesigning
24 the system enough to measure up with consumer

1 directed health plans. Thank you, Mr. Burton.

2 MR. BURTON: Thank you, Alan. Last
3 but certainly not least, Delia Vetter, senior
4 director of benefits from EMC Corporation.

5 MS. VETTER: Thank you, it's a
6 pleasure to be here today, and EMC is a global
7 employer employing over 40,000 employees on a
8 worldwide basis, about 22,000 in the U.S. and
9 approximately 9,000 in Massachusetts.

10 Over the past eight years EMC has been on
11 a journey of health care cost containment and the
12 journey really encompasses engaging the consumer
13 or the employee and the family member, so, driving
14 partnership and health has been our motto at EMC
15 and integrating technology to drive consumer
16 behavior has been a component of our journey.

17 Over the past eight years we have
18 launched a very sophisticated health education
19 program, health management, not health care
20 education program because we understand that
21 employees today understand the difference between
22 an HMO and a PPO.

23 Certainly it's about health management.
24 When we looked at our costs eight years ago, it

1 became clear that if we did nothing, our costs
2 would increase in five years, and we took that
3 responsibility very seriously because the costs
4 would increase not only for EMC, the company, but
5 for employees as well because as we all know,
6 employees share in the cost of health care.

7 And driving cost containment to EMC is
8 driving good health and helping employees and
9 family members engage in healthy lifestyle
10 programs, so, at EMC we didn't take, we didn't
11 develop the programs arbitrarily, we looked at
12 data.

13 In order to develop the right programs
14 that are targeted and meaningful to the
15 individuals so that the individual will engage,
16 they need the, the programs need to be meaningful
17 and looking at data on the aggregate we can
18 clearly see where the areas of need or of concern
19 are within our population.

20 We developed programs on a regular basis
21 and offer these programs, health management
22 workshops to our employees and family members on a
23 monthly basis based on the trends that we see in
24 the data and we have very high engagement in those

1 types of programs.

2 So, that's what I call the high touch of
3 our component of our strategy. Now, the high tech
4 component of our strategy is integrating
5 information to drive consumer behavior by
6 collecting information through a third party in a
7 data warehouse and providing our employees and
8 family members with a personalized health portal,
9 that's personalized to the individual based on the
10 information, on the claims information that's
11 transmitted from the data warehouse to the health
12 portal.

13 That health portal then drives targeted
14 and meaningful messages, leads employees to
15 programs that are available at EMC and it also
16 provides a patient's safety component because
17 within the health portal there's a personal health
18 record that's collecting information or
19 utilization on prescription drugs that are being
20 purchased by the patient or by the consumer and it
21 also, that type of health portal looks for drug
22 interactions and sends alerts to the individual if
23 there might be drug interactions.

24 So, it's also a patient safety portal as

1 well and it helps employees look at the best
2 hospitals potentially for elective surgery based
3 on Leapfrog standards or quality outcomes, so, at
4 EMC providing or containing costs is about
5 managing health, not shifting costs to employees.

6 Over the past five years we have managed
7 our success of our programs in driving partnership
8 and health and from a cost containment
9 perspective, approximately 112 million dollars in
10 cost containment within a five-year period.

11 So, our trend, we're measuring our
12 success based on our trend, we are self-insured,
13 compared to the national average and on an average
14 cost per capita we would have calculated 112
15 million dollars worth of cost containment. It's
16 never savings as you know because health care
17 costs continue to increase.

18 We have a very engaged population, the
19 tools of the personal health record introduced in
20 2004, which EMC was the first employer to
21 introduce a personal health record, and initially
22 I have to say that employees were a little nervous
23 about privacy but five years or six years later we
24 have very good engagement.

1 About 50 percent of employees at EMC are
2 using the personal health record and our goal
3 through marketing efforts is to get that to a
4 hundred percent. Our interactive health portal,
5 we have 90 percent participation in the health
6 portal and completing a health risk assessment is
7 more than just completing a health risk assessment
8 and maybe getting a report that helps you identify
9 areas that you might need to focus on, it also
10 provides us with aggregate information to help us
11 better understand our population on a very
12 proactive basis.

13 So, looking at the population very
14 proactively through the data on the health risk
15 assessment, looking at areas of risk and also
16 looking at the claims information on the
17 prospective basis to help us drive the right
18 programs.

19 And one more point is that the
20 information that's collected and that's shared
21 with the interactive health portal, the
22 interactive health portal is populated based on
23 the information that's being, that's transmitted
24 from, from the data warehouse, the claims

1 information.

2 So, at EMC we have high engagement
3 driving partnership and health, Health Link which
4 is our health portal is a household name, and
5 that's very important because as employers many
6 times we roll out programs and we'll roll out
7 tools and they lay idle.

8 At EMC we're very active in managing and
9 employees are very active in engaging. We have
10 high satisfaction and we are according to
11 employees through a survey that we did through our
12 health care partner, Excellent, we are, EMC is a
13 trusted source for employees.

14 So, employers have a very unique
15 opportunity to help drive good health in the
16 Commonwealth of Massachusetts and within the
17 employer setting, using the right tools and the
18 right data to drive the right behaviors and the
19 right engagement, and ten years ago, twenty years
20 ago, employers took a very passive approach in the
21 health plans.

22 We really left it to the health plans to
23 manage cost and to manage health, but today it's a
24 new era and employers need to be very actively

1 involved in managing their cost because it is
2 their cost, whether it's paid through premiums or
3 through a self-insurance model, it's still the
4 employer that's paying the majority of the cost,
5 so, the active involvement, collaboration and
6 coordination models, all stakeholders, that
7 includes employers, the health plans and employees
8 we feel is what will drive health care and cost
9 containment and good health in the Commonwealth.

10 Thank you for the opportunity to speak to
11 you today.

12 MR. BURTON: Thank you very much,
13 Delia. My first question is I want to acknowledge
14 I drive onto the Maine Turnpike from time to time
15 to buy a shirt at LL Bean instead of the local big
16 box store, I'm curious under the assumption that
17 there is a correlation between cost and quality.

18 I was wondering if the panel members
19 would react to the Attorney General's report in
20 this major finding that there is none in terms of
21 the way health care providers are paid.

22 As business people does that surprise you
23 or how do you react to that, what forces it might
24 unleash? Alan, you look like you have an answer.

1 MR. MacDONALD: It's not surprising
2 to me actually, there is different price items for
3 everything on the market. What we had a hard time
4 doing is defining a market that differentiates the
5 product to go with the pricing differentials. I
6 mean there are price differentials in every
7 product.

8 We don't look at health care as a
9 commodity like a box of Wheaties or whatever
10 that's going to be the same everywhere you go,
11 it's going to depend on a number of things, the
12 level of expertise, the overhead and every other
13 thing that relates to an individual provider, but
14 the very transparency is the magic word but the
15 very awareness among the consuming public of what
16 the differences in pricing and quality is what
17 we're trying to drive towards because that is a
18 very important thing.

19 MR. BURTON: Michael, would the
20 Taxpayers Foundation be surprised to find out the
21 taxpayers are paying more for a product that the
22 Attorney General doesn't feel is greater quality?

23 MR. WIDMER: No, not at all, though I
24 have not seen any evidence of that until the

1 Attorney General's first-class analysis that laid
2 it out. I mean as Alan suggests, I mean you've
3 got vast differences in price and quality in
4 almost all products so that's not surprising.

5 Market leverage is part of what the
6 economic system is about whether we like it or not
7 like it, so, I think in this case we're not
8 talking about a product whether it's an option to
9 buy or not, we're talking about health care, so,
10 the seriousness of it is much greater, and
11 therefore, the question of how are we going to
12 address market disparities becomes more, more
13 crucial.

14 But I think it's very complicated, the
15 thrust of my earlier comments and I think we can
16 legislate the reduction of market disparities in a
17 simple fashion, and that's the Attorney General
18 has not recommended that and I think they
19 repeatedly say they're not recommending that and I
20 think that's important because in this case I
21 think the quick fix will in fact make it worse.

22 MR. BURTON: I have a question for
23 Delia, managing health seems very important to
24 EMC, how do you know if it is working and the

1 correlating question is is percent of the parties
2 is down or is the average use down?

3 MS. VETTER: I'm sorry, what was the
4 last part?

5 MR. BURTON: The question after that
6 was is the percent of high users down or is
7 average use down?

8 MS. VETTER: Right, so, the, we know
9 it's working I'll say probably in three different
10 ways, we're measuring our success again on the
11 average cost per capita of our trend versus the
12 national trend, that's one.

13 Two, we have some unique programs through
14 a partnership with Boston University School of
15 Medicine, we launched a program called the DASH
16 program, which is a dietary approach to stop
17 hypertension.

18 It was actually a clinical study and our
19 employees, that was our very first program and
20 employees that participated in the program that
21 were hypertensive and participated in the program
22 for two years and there was a claims data that we
23 or actually an external party could track.

24 We saw a savings of nearly a thousand, a

1 savings in cost containment, both together nearly
2 a thousand dollars per individual that were in the
3 program, so, managing hypertension just through a
4 scientifically based nutritional program worked,
5 so, that's one metric.

6 Recently with the Centers for Connected
7 Health we launched another pilot program called
8 the Smart Beat program which was a remote patient
9 monitoring through a Bluetooth device, employees
10 would take their blood pressure that were
11 hypertensive, there was a control group and
12 intervention group, 400 employees and those that
13 participated in the program and followed the
14 direction of the clinician we saw a drop in their
15 blood pressure, and when we looked at that
16 program, we're still calculating the ROI, but it
17 could be about \$2 for every dollar spent.

18 So, those are the two programs that we
19 measure that weren't arbitrary that were actually
20 measured with data and then our trend.

21 MR. BURTON: Thank you. Getting back
22 to the previous question, if there is no
23 correlation between cost and quality what
24 motivation does an organization have to improve

1 quality? Alan, would you like to?

2 MR. MacDONALD: Well, I, the
3 motivation and patient safety and reputation of
4 the provider for sure, but I think quality is
5 going to be related to cost and that's what we'd
6 like to get to.

7 You know, we look at any provider and
8 there are no two that are identical, so, every
9 provider needs to reach their overhead of what
10 they're providing.

11 They may have a different combination of
12 procedures A, B and C compared to somebody else,
13 it's also got to get to their overhead, so, we do
14 see as in every other market there are going to be
15 differences in prices but they should very well
16 relate to quality for sure.

17 So, I think from the provider point of
18 view they must in their mind relate to quality but
19 to the consumer they're going to relate to
20 quality, convenience and other things that is true
21 in other markets.

22 MR. BURTON: We'll have to invent a
23 new system, the DQM, we'll call it
24 T leverage -- okay.

1 MR. WIDMER: May I ask?

2 MR. BURTON: Sure.

3 MR. WIDMER: Add something, I think
4 across this state whether you look at insurers,
5 providers, employers, consumers, there is an
6 enormous collective investment and focus on
7 improving the quality of health care in this
8 state.

9 So, I just want to and everybody in this
10 room, almost everybody in this room is involved in
11 one such effort or another, so, I don't want any
12 suggestion that somehow quality is diminished in
13 terms of the reality of what's happening in this
14 state and the extraordinary focus on that among
15 all parties.

16 MR. BURTON: I think it's important
17 to note that the Attorney General very clearly,
18 the quality is high across the board, she was very
19 clear about that but this is an interesting, I
20 do -- Frank.

21 MR. ROMANO: Question, the Attorney
22 General gave us the raw data, I'm interested in
23 what consumers perceive, do they perceive that
24 community based hospitals and hospitals in general

1 or do they perceive the Boston teaching hospitals
2 have better health care, has anyone done that
3 study to look at what consumers' perception is of
4 quality of care? I'd be curious to see what that
5 data that came up that correlated against your
6 hard data.

7 MS. COAKLEY: We haven't done that
8 study.

9 MR. BURTON: If there is no
10 correlation between price cost and quality what
11 are we paying for? Maybe have Frank or Eric.

12 MR. MICHELSON: I mean what I took
13 away from the Attorney General's talk was that the
14 same falls on us as falls the providers, it all
15 comes down to leverage.

16 I see firsthand what the lack of leverage
17 costs my business every year in both the baseline
18 premiums and the growth rate of the premiums and I
19 just feel that, you know, I'm not providing my
20 employees what best they can get because I don't
21 have that buying power.

22 MR. BURTON: I'm curious, Peter, you
23 have tremendous market leverage as one of the
24 largest insurance companies, do you have the same

1 leverage in the health care market when you go out
2 to purchase?

3 MR. MONGEAU: I think our success
4 isn't so much a result of our size, I think it is
5 a result of what I shared in my comments, that we
6 have a focus and a collaborative focus with the
7 health plans and looking at pilot, pilot programs
8 and testing them to see whether they have an
9 impact on our employee health and productivity and
10 then continuing with those, and I think it's that
11 spirit of partnership that has been more
12 successful than the fact that we're a large
13 employer in the state.

14 MR. BURTON: Any further thoughts on
15 what you've heard?

16 THE AUDIENCE: I just have one
17 question, you said you have 40,000 employees and I
18 assume some of them are in other countries.

19 MS. VETTER: Yes.

20 THE AUDIENCE: Is there any comment
21 you would make about your program with those
22 purchasing health care in other countries and how
23 that, you know, how those systems are used, you
24 know, what, what those employees, how they respond

1 to them and is there anything that sheds any light
2 on what happens, what's the difference between
3 there or any of them and us?

4 MS. VETTER: Yes, that's a good
5 question, so, we focused over the past eight
6 years, really focused in the U.S. because abroad
7 as you know it's so, it's so difficult all of the
8 different laws and regulations and so forth and we
9 do have a very high population abroad, but I will
10 say this, Canada is our next target.

11 In the U.S. once we've stabilized the
12 employee population in the U.S. and the cost
13 containment, we'll move to Canada and also
14 internationally.

15 We had other employees that, we all share
16 the same E-mails and oftentimes we'll advertise or
17 market health management programs or we'll talk
18 about PHR and an employee from Sweden, this was a
19 true story, was visiting and said hey, how come I
20 don't have that.

21 So, they're starting to think about
22 different tools and different programs, so,
23 eventually over the next maybe five to eight years
24 we'd like to expand abroad, but again it's a bit

1 more difficult and it's expanding not on
2 purchasing, it's more on the health management and
3 creating that same type of philosophy and strategy
4 as in the U.S.

5 MR. O'BRIEN: I have a follow-up
6 question, you mentioned and I think a number of
7 the panel have talked about case management and
8 failure to have sort of preventive care, have you
9 found through your work that the shift towards
10 preventive primary care has been the bigger
11 percentage of your premium dollar than what it is
12 nationwide?

13 MS. VETTER: Oh, to me, okay, well,
14 what's interesting is on the preventive care, the
15 data indicates to us that preventive, our
16 employees were very good at preventive care, 12
17 percent of our health care costs are on preventive
18 care.

19 So, I don't think there's been any
20 increase in preventive care, what we see is better
21 management of chronic conditions, okay, so, we see
22 much more active management of chronic conditions
23 versus just an increase in the preventive care.

24 MR. O'BRIEN: And as far as lessons

1 for other employers both on getting to be good at
2 primary care and managing chronic conditions, are
3 there takeaways, is it data driven or are there
4 other takeaways that the other employers can learn
5 from your experience.

6 MS. VETTER: Yeah, it's data driven.
7 Looking at the data, we understand and it's been
8 published that 50 percent of health care costs are
9 attributable to lifestyle modification and looking
10 at the data such diseases or conditions such as
11 hypertension and asthma and so forth, circulatory
12 type of conditions, managing those conditions are
13 as key to containing costs and driving good
14 health.

15 So, as an example, at EMC when an
16 individual takes a health risk assessment, if
17 they've been identified at risk for a particular
18 condition or if they self-disclose a particular
19 condition, that information is shared with
20 lifestyle coaches and there's outreach, so,
21 lifestyle coaches will reach out to the individual
22 and get them engaged in a program, so, the data is
23 key to driving our success in our programs.

24 MR. BURTON: Would your business or

1 businesses that you are familiar with be open to
2 considering use of such strategies as limited
3 network plans that encourage use of lower cost
4 providers, tiered network products, small group
5 purchasing via an exchange or cooperative such as
6 a Commonwealth Health Insurance Connector and
7 there was a corollary question, as employers do
8 you think your employees will be satisfied with
9 narrow network projects given the conclusion that
10 there is no difference in provider quality?

11 But the main question is would you be,
12 are you familiar with and considering these other
13 three strategies, limited networks, tiered
14 networks and small group purchasing.

15 MR. MONGEAU: As far as the first two
16 options, yes, it is something we would consider
17 and I think I would want to add to two earlier
18 questions and kind of weave them together.

19 By way of the data that is currently
20 available, although it might be disappointing with
21 respect to cost and quality, we're very encouraged
22 that it's a baseline, we have a starting point in
23 which to build and I think that that is a huge
24 success.

1 With respect to what makes the programs
2 successful and what would make the two programs
3 that I said we would consider successful on a
4 go forward basis is they need to be data driven,
5 sound data driven but another element and what has
6 made programs successful is we're dealing with
7 consumers.

8 So, communications, branding, culture are
9 all critical and these are elements that a company
10 can bring to the table effectively because of some
11 of the inherent nature of the way a company
12 operates, so.

13 MR. ROMANO: It's interesting, I
14 think larger companies have a great advantage and
15 I think some of the things that they are both
16 doing is wonderful, but when you get to be a
17 smaller company you don't have all those
18 resources, and it seems to me in Massachusetts,
19 when you're speeding, you get a ticket, your
20 premiums go up for the next three years I think,
21 and I envision two employees in our company, one
22 paying half the amount of another employee if they
23 don't smoke, if they're not overweight, if they
24 take their health assessment, if they do their

1 yearly physical.

2 So, I'm going back to fiscal
3 responsibility of the individual employee. Forget
4 motivating, I'm going to motivate them with
5 dollars. As an ex IBM salesman, that's what
6 motivated me was how did I sell.

7 And so, my feeling is if you want to live
8 an unhealthy lifestyle, you're going to pay for
9 it. If you want to, you know, do something else
10 that's the way it is. That's what happens I guess
11 when you're an ex Third Marine Tank Commander in
12 Vietnam, you know, what are you going to do, I
13 just tell you I came out of that background.

14 I mean at this point I'm so frustrated
15 with trying to get it to work that I have to do
16 something or I'm not going to be here five years
17 from now and I've got to figure out how to do it.

18 MR. BURTON: Why am I not surprised
19 you were a tank commander. I had Delia was
20 responding to that question and then Alan.

21 MS. VETTER: Yes, just in response to
22 that question and another comment, on price
23 transparency which is very important to the
24 consumer because we know that they are not aware

1 of what health care truly costs, and so, price
2 transparency at EMC is now available to employees,
3 through the personal health record employees each
4 time their office visits and their diagnosis, all
5 the information is transmitted into their personal
6 health record, they can see how much that that
7 care actually costs and I can tell you that it's
8 an eye opener.

9 We have had individuals that have looked
10 at their personal health record and they've seen
11 that they've spent out of pocket for a copay say
12 at a hospital \$250, and their surgery or their
13 procedure was 50 or \$60,000.

14 So, think of the price transparency is so
15 important to increase the value of, the procedure
16 value of employer sponsored health care, so, price
17 transparency is key, and in response to your
18 question on the tiered networks, yes, we would
19 consider tiered networks because we feel that too
20 that employees are shielded from the fact that
21 every provider is equal and we know that that is
22 not true.

23 MR. BURTON: Alan.

24 MR. MacDONALD: I was going to say

1 yes, a tiered situation, we did a report in 2002
2 which looked at the fact that quality care at an
3 appropriate setting where you would say whether it
4 be community setting or a health center, health
5 clinic versus what would be a more expensive level
6 of treatment for the same result, we said to
7 ourselves at that time if you could have the
8 chooser choose a more expensive setting for the
9 similar result, they ought to pay at least part of
10 the choice, that we would never want to deny
11 anyone the opportunity for the same result at an
12 appropriate setting but we also wouldn't want to
13 deny choice.

14 So, if somebody wanted to do that in a
15 system that is subsidizing everything, that they
16 ought to pay for it themselves. That's why we
17 weren't surprised at the differentiation on the
18 price because demand is what dictates price a lot
19 of times, quality we assumed to be very good at
20 the lower price level, we find that to be true,
21 but price relates not only to quality but demand.

22 And so, when the product is subsidized
23 demand goes up of course and we subsidize in our
24 system everybody from the highest income earner to

1 the entry level position on the same policy, so,
2 why would we expect any different in their
3 behavior with that kind of subsidy, but if we say
4 that those who can afford to make the choice,
5 bless them and let them make the choice but let us
6 not have to subsidize the choice that someone
7 makes that they can afford for the same result at
8 a lower level, so, we're all for that system.

9 MR. BURTON: Eric.

10 MR. MICHELSON: The limited network
11 idea, that's a drawback especially with middle and
12 older aged employees because they have developed
13 great relationships with doctors.

14 I mean the first question my wife asks me
15 when I come home and say we're switching insurance
16 again this year is well, are the kids' doctors on
17 the plans, you know, is my doctor on the plan?

18 So, it really, we have to look at these
19 things very carefully and we actually took a good
20 look at the Business Express program offered by
21 the Connector and found that the majority of the
22 doctors that we were currently seeing weren't
23 covered in the networks and some of our employees
24 have long-standing relationship with specialists

1 that weren't covered.

2 So, at this point in time, at this point
3 in the system going on a limited network is very
4 difficult for us. Tiered plans we would consider,
5 smaller groups we would consider also, but going
6 back to the discussion we were having about the
7 fact that these programs contribute better to your
8 cost control than the leverage or the size of your
9 group, as a small business I don't have the
10 overhead, I don't have the staff, the time, the
11 critical mass of employees to roll out wellness
12 programs or these great programs that Frank and
13 Delia talk about, I mean Peter and Delia talk
14 about, but I would love to have my employees be
15 able to avail themselves of that and get cost
16 savings but that would fall into the hands of my
17 employer, I mean on my insurer, so, it's a real
18 problem.

19 MR. BURTON: The report opines that
20 businesses across all categories are reducing the
21 size of benefits, if this is the case for your
22 business or businesses you are familiar with how
23 have your employees responded?

24 I might answer myself, I'm in the Mass.

1 insurance state system and we did have our
2 benefits reduced and there was some reaction but
3 like Michael said, the way that the state plan
4 works is it's not subject to everyone in the
5 system but took a higher copay simply to keep the
6 system solvent.

7 Have you had experience with this in your
8 businesses where you reduce benefits as the report
9 has said and what's the reaction?

10 MR. ROMANO: Honestly employees don't
11 like it at all and it is a real issue and they are
12 very upset over it. I mean last year we wiped out
13 chiropractor services as part of something covered
14 because we wanted to save money there.

15 It is difficult. Employees today see
16 that they are paying, many companies are asking
17 the employee to pay more of the health insurance,
18 so, I see it as a real problem and we have to find
19 a better way.

20 We just can't keep cutting and asking to
21 pay more, that's just not going to work.

22 MR. BURTON: Other panelists, Peter.

23 MR. MONGEAU: We have had actually
24 success, we've been fortunate that the changes

1 we've made to our health plan have not been
2 drastic and they have been ones that are in line
3 with what I have spoken about in particular with
4 respect to trying to weave in some element of
5 accountability when the data is there for
6 employees to make wise decisions.

7 We also look at the total deal for our
8 employees, so, that we're conscious of what we
9 pay, the culture, the organization, et cetera, and
10 our survey data actually indicates that employees
11 are quite satisfied with what we are offering,
12 benefits and else wise.

13 MR. BURTON: Delia.

14 MS. VETTER: Likewise, at EMC we've
15 been very fortunate that we have not increased
16 copays or deductibles since I think it was either
17 2004 or 2005, so, each year we continue to again
18 just to focus on the cost containment on the
19 health management, we've increased employee
20 contributions in the single digits while we know
21 that other employers are increasing in the double
22 digits, so, similar to Peter we have had very good
23 success and have not had takeaways.

24 MR. BURTON: Last question, what

1 impact do you think transparency of quality in
2 cost providers would have on your business or
3 businesses you are familiar with, what specific
4 kind of information on price and quality would be
5 most helpful to you in considering benefit design
6 or benefit purchasing, anyone? Don't speak at
7 once. Yes, Frank.

8 MR. ROMANO: I think it's great, I
9 mean I think employees, if we did a study on what
10 employees think, I think they think some of the
11 teaching hospitals provide better health care.

12 Once they understand that the local
13 regional hospital can provide good health care to
14 them at a better price, then I think that's a big
15 win, so, I came away with that today.

16 I've got a piece of data now that I can
17 talk to my employees about and let them understand
18 that that perception isn't always the case.

19 MR. BURTON: From the nodding heads I
20 take it the rest of you agree with that. Any
21 further comment on that? I can't conclude without
22 mentioning, in deference to what Michael said,
23 that all of the chambers are supporting paid plan
24 design for the municipalities right now which is a

1 tough situation, but I think as Michael said it's
2 a critical area now and it's going to be a tough
3 issue but that's where the towns get to design the
4 plans for their employees and millions of dollars
5 I understand, Michael, would be saved due to that
6 method.

7 MR. WIDMER: Well, yeah, save tens of
8 millions of dollars and it would compound over
9 time, but the other thing to underscore is in the
10 legislation, there would be protection that the
11 plans would be no worse than if you will or on a
12 par with GIC, so, that the notion that somehow
13 you're going to, some town will just basically
14 jettison health care benefits for employees and
15 retirees would not be the case.

16 There would be a protection because even
17 with the changes in the GIC, the state employees,
18 retirees, it's a very good plan, so, that protects
19 you there.

20 MR. BURTON: Unless there's any
21 further questions or comments, that concludes this
22 panel. I'd like to thank profoundly our panelists
23 today for taking time to come in, and thank you
24 all very much.

1 (The audience applauded.)

2 MR. MORALES: Thank you, and we're
3 going to take a ten-minute break and come right
4 back.

5 (A break was taken.)

6 MR. MORALES: And I'd like to invite
7 Commissioner John Auerbach, Commissioner of Public
8 Health, to the podium.

9 MR. AUERBACH: Thank you,
10 Commissioner Morales, and thanks to all of you who
11 have stayed throughout the day and are still here
12 to hear the testimony of this important panel.

13 I want to in particular thank
14 Commissioner Morales for including the voice of
15 the consumer in these three days of hearings and
16 thank you for your leadership in terms of ensuring
17 that consumers are a part of the process, that is
18 important because fundamentally, health care is
19 about meeting the needs of the consumer of care
20 and it's the patient who benefits when care is
21 both high quality and accessible and it is the
22 patient who suffers when care is neither of those,
23 and consumers in fact do care about costs for many
24 reasons, those include such things as the impact

1 of the cost of premiums, the impact of copays and
2 deductibles on the one hand and it also, consumers
3 care about cost also because of cost related
4 decisions that may affect them, such things as
5 limiting the benefits that are available to them
6 or limiting the providers or the facilities they
7 can visit are all related to costs, and consumers
8 also are, approach the issue of health care not
9 just in terms of clinical care in a narrow sense
10 but they're concerned, we're concerned as patients
11 with our overall health, overall wellness, and
12 therefore, take a broader perspective on thinking
13 about this issue and think about all the
14 conditions of our lives, not just the clinical
15 visits that do have an impact, and some of those
16 conditions of life often called the social
17 determinants of health, patients understand have a
18 critical role in terms of complementing what takes
19 place in the clinical settings.

20 And so, not surprisingly since consumers
21 and patients care about cost, consumers and
22 patients want to have a role and a voice in
23 shaping policy and in determining their premiums
24 and the way the care is delivered.

1 So, to discuss all of those issues I'm
2 delighted to introduce the esteemed panel that you
3 see before you and following the format that was
4 used in the last panel, I'll be introducing each
5 one of the panelists one at a time, they'll speak
6 and then following each of their presentations
7 we'll engage in a question and answer period.

8 So, the first person who will be speaking
9 is known to many of you is Amy Whitcomb Slemmer,
10 Amy is the executive director of Health Care for
11 All, Amy.

12 MS. SLEMMER: Thank you so much,
13 Commissioner Auerbach, for facilitating this
14 panel. Health Care for All is pleased to
15 participate in these hearings and we commend the
16 Division of Health Care Finance and Policy for
17 their exemplary work in producing the detailed
18 cost trends report and for their dedication to
19 transparency and for organizing today and the rest
20 of the week, thank you so much.

21 Health Care for All is a nonprofit
22 consumer advocacy organization dedicated to
23 creating a consumer center health care system that
24 provides comprehensive, affordable, accessible

1 competent high quality care and consumer education
2 for everyone especially the most vulnerable people
3 among us.

4 Much of HCFA's work is conducted through
5 state coalitions, and we convened the
6 Massachusetts Coalition for Better Care, a broad
7 network of consumer organizations working together
8 to achieve comprehensive payment reform.

9 I'm pleased to be joined by a number of
10 our coalition members this afternoon who will
11 speak on their own behalf but also some for their
12 own individual organizations.

13 We believe that it is imperative that we
14 tackle the cost and quality challenges in our
15 health care system as quickly and effectively as
16 possible. As we know that thousands of consumers
17 are struggling to pay for their annual premium
18 increases in order to maintain access to our world
19 renowned and expensive health care system.

20 The cost trends report highlights the
21 fact that health insurance premiums and the price
22 of medical care are escalating at an alarming
23 rate. As you gather testimony this week, we urge
24 everyone to remember that it's the Massachusetts

1 consumers who shoulder the brunt of these ever
2 increasing costs. We strongly believe that
3 consumers must be at the center of any
4 conversation about health care costs and propose
5 policy solutions.

6 Our work on cost and quality is shaped by
7 help line callers like Melissa and Tom, a couple
8 who opened a small business in 2008 and thanks to
9 our health reform law qualified for affordable and
10 comprehensive health insurance through
11 Commonwealth Care. Their two young daughters
12 receive their care through Mass Health.

13 By the end of their first year in
14 business Melissa and Tom had earned \$70,000 which
15 is a success in any economy but a remarkable
16 achievement in our current circumstances.

17 Unfortunately, it was also more than the
18 allowable limit for a family of four to qualify
19 for the sliding scale premiums and that they
20 depended on to pay for their health insurance.

21 In order to retain comprehensive
22 coverage, Melissa and Tom's premiums were quoted
23 to be \$12,000 a year which was a quadruple
24 increase in their cost they paid under Comp Care,

1 and even with a tight family budget absolutely
2 this number and cost was unaffordable, so, this
3 Massachusetts family is currently uninsured.

4 The preliminary report released by the
5 Attorney General on cost trends and cost drivers
6 found that our competitive marketplace is not
7 operating in a fair and balanced way and that
8 market mechanisms are not serving public needs.

9 I'll quickly highlight four areas of
10 concern and related opportunities and we will
11 fully agree with and endorse the points that you
12 will hear from the other consumer representatives
13 this afternoon.

14 First of all, consumer engagement can
15 lead to lower costs and better quality. The most
16 critical component necessary to containing health
17 care costs in a sustainable way is to engage
18 consumers as partners in their own health care.

19 We know that there are innovative
20 programs that have demonstrated increased patient
21 skills and lower overall costs and we believe we
22 must revise our payment system so that programs
23 like these are supported to improve the quality of
24 care, improve patient satisfaction and lower

1 overall health care costs.

2 The second thing we believe strongly in
3 is that transparency is a prerequisite to
4 effective oversight, patient understanding and
5 public accountability.

6 We strongly urge policy makers to expand
7 public transparency of our health care payment
8 system. The AG's report indicates that there are
9 supplemental payments from insurers to providers
10 that are not related to patient volume, patient
11 acuity or meeting other health care quality
12 standards.

13 We welcome public scrutiny of these
14 payments in order to better understand how they
15 benefit patients. How many times have we heard
16 the patients have no idea how much our tests and
17 procedures cost.

18 We urge the Division and other state
19 agencies to fully disclose complete information on
20 prices, contracts and financial arrangements in
21 our health care system.

22 The third thing we feel strongly about is
23 that cost reduction and quality improvement can be
24 achieved by rewarding coordinated care. Our

1 current payment structure rewards quantity of
2 service and not quality.

3 We are endorsing the eventual elimination
4 of payments for unnecessary duplicative tests,
5 preventable hospital readmissions and medication
6 errors. These efforts are of no value to patients
7 and cost our health care system necessary dollars,
8 dollars that would be better spent incentivizing
9 providers to keep us well and out of hospitals.

10 We want all Massachusetts residents to
11 receive the health care they need when they need
12 it. This care must be coordinated so that
13 everyone is kept healthy as possible and not just
14 patched up and sent on our way until the next
15 acute episode.

16 Fourth, we believe an expanded investment
17 in public health and public prevention programs
18 can also reduce overall costs. The health care
19 quality and cost roadmap to cost containment
20 emphasized the critical role that public health
21 plays in addressing overall health costs.

22 We endorse community and employer
23 engagement efforts that focus on improving our
24 health like increasing walkable schools, school

1 routes as well as key regulatory changes like
2 nutrition labeling, and finally, we believe
3 strongly in the investment of public health
4 campaigning like substance abuse prevention in as
5 cost effective ways in attributing overall public
6 health and thereby delaying and reducing the
7 dollars needed for our health care.

8 We think that investments in public
9 health pay long term and wide ranging dividends
10 throughout the Commonwealth and believe our
11 current public health spending must be increased
12 as a vital part of payment reform.

13 Health Care for All looks forward to
14 working closely with the Division, the Attorney
15 General and other state officials on health care
16 cost containment and quality improvement efforts.
17 With Chapter 58, Massachusetts pioneered health
18 care reform. We showed the nation how we could
19 expand coverage to almost everyone in the
20 Commonwealth.

21 Now we have the opportunity to lead the
22 way by taking bold steps to control the costs and
23 improve the quality of care that our health care
24 system delivers. We know that the Governor and

1 this administration are committed to this goal and
2 we pledge our best efforts to make the changes
3 that are needed to serve the interest of patients
4 who must be at the center of this next phase of
5 health reform. Thanks very much.

6 MR. AUERBACH: Thank you, Amy, for
7 that presentation and for the brilliant
8 observation about the value of public health.

9 MS. SLEMMER: I liked that.

10 MR. AUERBACH: Our next speaker is
11 Deborah Banda, Deborah is the Massachusetts state
12 director for the AARP, Deborah.

13 MS. BANDA: Thank you, AARP is a
14 membership organization for people over the age of
15 fifty and we constantly hear heartbreaking stories
16 from our members. We know that the cost of health
17 care is one of the most important personal and
18 economic issues they're facing right now, not only
19 for themselves as aging Americans but for their
20 children and their grandchildren.

21 I'd like to tell you just three quick
22 stories to sort of put a face on what it is like
23 for these folks. Ann is sixty-three years old,
24 she's self-employed and she lives on the Cape.

1 She buys her health insurance through a small
2 group. In 2002 her premiums were \$400 a month and
3 that sounds very bad. This year they're \$1,059 a
4 month.

5 She is healthy and she takes no
6 medications. She told us just yesterday that
7 she's considering reducing her coverage to
8 something more affordable. She also told us that
9 she's thinking of moving out of the country
10 because she just can't afford to live here anymore
11 and have the health insurance coverage she needs.

12 We heard a similar story from a
13 sixty-three-year-old Danvers woman and she told us
14 every time she thinks about what it costs her to
15 stay insured, she feels like she is being hit in
16 the face.

17 Another story, Pat from Salem is
18 fifty-nine, she went on Medicare early because of
19 disability. In 2008 she and her husband spent
20 nearly \$15,000 on out-of-pocket health care costs.
21 She told us it's a struggle and I think that's
22 probably a massive understatement on her part.

23 I have filed much more lengthy testimony
24 but I want to briefly confine my remarks today to

1 two areas of particular concern to our aging
2 population when it comes to confining costs and
3 which are critical, namely, the role of better
4 care coordination on reducing the need for
5 institutional care and also the need to support
6 family caregivers.

7 Better care coordination as Amy indicated
8 is critical to reducing costs while improving
9 quality of care and quality of life for those
10 folks with multiple chronic conditions.

11 It's especially important to older adults
12 who are more likely to have chronic conditions and
13 who are likely to have family or other informal
14 caregivers who are struggling to help them.

15 Good chronic care coordination can help
16 keep individuals out of more costly institution
17 settings and providing the supports to live
18 independently can help delay or prevent
19 institutional care.

20 Supportive services or home and community
21 based services can often be provided more cost
22 effectively than care in an institution setting.
23 For example, some of our research shows that on
24 average Medicaid dollars spent on home and

1 community based services can support nearly three
2 older adults and individuals with disabilities for
3 every person at that same price cost for a nursing
4 home.

5 Other recent research indicates that
6 states that make long term commitments to
7 increasing home and community based services while
8 diminishing their reliance on nursing home
9 services can realize long term savings; however,
10 we know that such a commitment requires short term
11 transitional costs that states can have trouble
12 paying for right now especially in these tough
13 economic times.

14 Enhanced federal Medicaid matching funds
15 for home and community based services could
16 provide the incentives to make short term
17 investments that result in long term budget
18 savings and improve lives for older adults and
19 people with disabilities who need these services.

20 Now, keep in mind that family caregivers
21 are often critical parts of an interdisciplinary
22 care team helping to meet the needs of an
23 individual with multiple chronic conditions;
24 however, we also know that caring for loved ones

1 can take a physical, emotional, mental and yes, a
2 financial toll on caregivers that is very well
3 documented.

4 To continue in their caregiving role and
5 to help ensure the provision of quality care and
6 reduce costs to the public and private payers,
7 caregivers need additional support.

8 It can come in a variety of forms, it can
9 come as an assessment of the caregivers' needs to
10 help them connect them to services such as
11 information and training and respite care, better
12 discharge planning, navigational assistance and
13 information about providers so as to make the best
14 decisions about care options, better
15 communications with providers as part of the care
16 team and also support from nurses and social
17 workers.

18 AARP has estimated that the economic
19 value of family caregivers' unpaid contributions
20 to be about 375 billion dollars in 2007, so,
21 supporting these folks is not only the right thing
22 to do, it is also the smart thing to do
23 economically as well.

24 So, we urge the Commonwealth to adopt

1 policy recommendations that initiate cost
2 containment measures that effectively constrain
3 growth in price, volume and intensive care
4 services without compromising quality of care or
5 inappropriately denying access to care.

6 We must ensure that cost containment
7 efforts do not result in efforts to shift costs
8 inappropriately to patients or other payers and we
9 urge you to develop policies that initiate tests
10 that evaluate payment approaches that create
11 incentives for providers to be more efficient and
12 more effective and that reward good outcomes,
13 thank you.

14 MR. AUERBACH: Thank you very much,
15 Deborah, and now I'll introduce Matt Selig who is
16 the executive director of Health Law Advocates,
17 Matt.

18 MR. SELIG: Thanks, Commissioner. I
19 just want to start by thank you very much,
20 Commissioner Morales, and his staff at the
21 Division of Health Care Finance and Policy and the
22 Attorney General and her whole staff for all the
23 effort they did putting together all the
24 incredible research that went into this, the

1 background for this hearing. I know that they did
2 an incredible job and I also want to thank the
3 Division of Insurance and the Department of Public
4 Health for all the work they've done as well, and
5 it's really a huge privilege to be up here with
6 all these incredible advocates up here, they're
7 all wonderful.

8 My name is Matt Selig and I'm the
9 executive director of Health Law Advocates, which
10 is a nonprofit public interest law firm that
11 provides free legal services to low income
12 Massachusetts residents having trouble accessing
13 health care.

14 We help nearly a thousand low income
15 consumers each year. Much of our work involves
16 helping consumers obtain insurance coverage for
17 their health care. We also handle many cases
18 involving clients who have medical bills for which
19 no insurance coverage is available.

20 What we see every day are consumers who
21 have enormous medical bills that they can't
22 afford. They're afraid to go in for badly needed
23 health care because they're scared to get more
24 health care bills and their lives have turned

1 upside down because of the cost of health care.
2 They lose any savings they may have, they lose
3 their housing, they drop out of school and their
4 credit is destroyed.

5 I'd like to describe one case that's very
6 typical of the situations we encounter. We were
7 contacted by a forty-three-year-old-man from
8 Boston I'll call Peter. Peter has dealt with
9 health issues his entire life.

10 He has congenital heart problems that
11 lead him to get a pacemaker when he was seven, he
12 suffered a stroke at a young age and has frequent
13 seizures since. A few years ago Peter was working
14 and earning about \$20,000 a year and he had health
15 insurance through his job which paid for about
16 90 percent of most health services.

17 At that time Peter went in for services
18 at a Boston hospital and also needed emergency
19 care by a hospital on the South Shore at a time
20 close to that. He ended up with hospital bills
21 for about \$1,600 from both institutions, but
22 Peter's income was only enough to cover basic
23 living expenses so he had no way he could pay
24 these bills.

1 Both hospitals referred the bills to
2 collection agencies which reported the debt to
3 credit rating bureaus. Neither hospital advised
4 Peter to apply for the Health Safety Net program
5 that would have covered the hospital bills if Tom
6 had applied even within a few months of the
7 services.

8 HLA attorneys contacted the hospitals on
9 Peter's behalf and after they examined the case
10 the hospital in Boston agreed to forgive the bill
11 for \$1,600 and their collection agency promptly
12 removed the debt from his credit report.

13 The hospital on the South Shore refused
14 to negotiate and said they did not offer discounts
15 to patients with insurance. The hospital also
16 claims their policies made it impossible for them
17 to remove this debt, the debt from Peter's credit
18 report until he paid the bill in full.

19 Peter's in and out of work because of his
20 health and simply cannot afford to pay these
21 bills. HLA handles cases like this all the time
22 and it illustrates the challenges consumers face
23 with the cost of health care.

24 I chose this case really because it's not

1 an outlier case, we do have cases involving tens
2 of thousands, hundreds of thousands of dollars
3 worth of debt, but this is a case where \$1,500,
4 \$2,000 worth of debt which to a person with
5 limited means is really an insurmountable amount
6 of money to pay but yet the kind of case that we
7 have all the time.

8 That's really all I have for now for my
9 testimony, and in closing I just wanted to say
10 that I'm look forward to participating in the
11 dialog today and in the future with policy makers
12 and all the other stakeholders in the health care
13 system to find solutions to contain the cost of
14 health care and improve the system for all
15 participants.

16 MR. AUERBACH: Thank you very much,
17 Matt. Our next speaker is Nancy Turnbull, Nancy
18 is the senior lecturer on health policy and
19 associate dean for educational programs at the
20 Harvard School of Public Health, Nancy.

21 MS. TURNBULL: Thank you,
22 Commissioner, I have to first note that I am
23 having my time kept by someone who used to be a
24 student of mine at the School of Public Health and

1 I just want to say to you I plan to ignore you as
2 much as you used to ignore me.

3 I appreciate very much the opportunity to
4 testify today about the consumer experience of
5 advising health care costs. I want to focus my
6 remarks on four different areas, a couple of which
7 have been touched on by other people today.

8 The first is the corroding effect that
9 rising health care costs are having on family
10 incomes; the second is the jeopardy to health
11 reform in Massachusetts of rising costs with
12 particular focus on individual mandate; the
13 fourth, the third is the opportunity costs of
14 rising health care spending in terms of our
15 ability to make investments in other important
16 areas that would improve health; and finally, I
17 want to end with the wisdom of Chicken Little.

18 So, the first point is one that Len
19 Nichols made I think very well and that's the
20 point that health insurance premiums are
21 increasing faster than incomes which is creating a
22 crisis of affordability for individuals and
23 families.

24 In Massachusetts health insurance costs

1 are rising at a rate that's three to four times
2 the rate of wages and I really commend any of you
3 who haven't read it, there was a great consumer
4 Commonwealth Fund report last year which I think
5 summed up what's happening well which was called
6 "How health insurance premiums are eating up
7 middle class incomes."

8 Individuals and families are devoting an
9 increasing share of family incomes to health care.
10 This is making it harder and harder for people to
11 pay for other living expenses.

12 The problem is compounded as we've heard
13 today from a few people on the fact that health
14 benefits are getting skimpier which means that
15 people are not only paying increasing premiums and
16 more expenses out of pocket and there's, there are
17 a variety of research studies that show that
18 rising health spending is making it ever more and
19 more difficult for people to save, for people to
20 save to buy houses, for people to save for college
21 education for children, for people to save for
22 retirement, so, lower savings rates that are being
23 caused by rising health spending will have
24 implications for decades to come and these

1 problems are particularly acute in Massachusetts,
2 where referred to today we have the highest health
3 insurance premiums in the country and where
4 household income is actually growing quite a bit
5 more slowly than the rest of the country.

6 The combination of these two things is
7 producing a situation which for me reminds me of a
8 video game some of you may be familiar with which
9 is called Pac Man or Pac Woman.

10 I actually would have done much better in
11 college had I not become so acquainted with these
12 games, but in Pac Man you may remember there are
13 four characters who are called Inky, Blinky, Pinky
14 and Clyde who are the only forces that can stop
15 Pac Man's insatiable appetite for more and more
16 Pac drops and energizers and fruits and power
17 pellets, and I think we actually need to develop
18 our own version of Inky, Blinky, Pinky and Clyde
19 in health care.

20 Otherwise, pretty soon it's going to seem
21 as if most people in the Commonwealth are working
22 for health insurance wages as a fringe benefit.

23 So, the second point is rising health
24 care costs jeopardizing health reform, we've heard

1 that from several speakers today. The point about
2 this I want to make is a somewhat different point
3 and this comes from my perspective as a member of
4 the Connector Board and board member, one of the
5 things that the Connector Board has to do every
6 year is set the affordability schedule and we did
7 this last week at our board meeting and this is a
8 schedule who determines who is subject to the
9 individual mandate in the state and it shows
10 different family configurations and different
11 income levels how much we've decided is affordable
12 for people to pay for health insurance or else pay
13 the penalty.

14 Now, when health insurance premiums are
15 increasing, that's for employer insurance,
16 individual insurance or any other kind of
17 insurance, the impact of the individual mandate,
18 how many people are actually subject to erodes
19 unless we increase the affordability schedule, so,
20 since the affordability schedule was adopted in
21 2007, every year the Connector Board has voted to
22 increase the affordability schedule.

23 We do it differently for people at
24 different income levels, but if you want to retain

1 the reach of the individual mandate, we have to do
2 that with health insurance premiums going up, but
3 although if you've ever been to one of our
4 meetings, you know we have a lot of differences of
5 opinion and philosophy about what's affordable in
6 this state, I think the one thing that we all
7 agree on on the Connector Board is the biggest
8 challenge we face in setting the affordability
9 schedule and reaching the individual mandate is
10 how fast health insurance premiums are going up
11 and it's simply not possible every year to
12 increase the affordability schedule 8 to 10 to 12
13 percent.

14 So, if we don't do that, we will find
15 that the reach of the individual mandate erodes
16 and in my view it should erode for reasons of
17 fairness and equity, so, finding ways to contain
18 health insurance costs are very important to
19 maintaining our progress in health reform.

20 The third point, and I hope Commissioner
21 Auerbach will think that I'm as brilliant as Amy
22 and others in making this point, is what
23 economists call the opportunity cost of rising
24 health spending.

1 For those of you who remember your
2 introductory economic courses, opportunity cost is
3 a fancy phrase that economists give to talking
4 about what do we forgo when we pay for something
5 in terms of what else we could have spent our
6 income on.

7 If you look at what are called the social
8 determinants of health and public health people,
9 the economic and social conditions that determine
10 the health of individuals and communities, you
11 find that actually medical care is pretty far down
12 the list of the social determinants.

13 There's lots of research that shows that
14 while access to medical care is important to
15 health, it's a lot less important than many other
16 things, it's a lot less important than education,
17 employment, income security, quality parenting and
18 early childhood development, food, housing, social
19 supports and all of the other things that
20 determine the conditions in which we work and
21 live.

22 So, as health care is consuming more and
23 more and more of both our private and public
24 resources, the consequence of that is actually

1 probably reducing our health ironically enough,
2 it's reducing our health by limiting the resources
3 we have available for all those other important
4 determinants of health, education, housing, income
5 support, all the other things that I named, and
6 the extraordinary state budget cuts to public
7 health over the last few years I think are
8 particularly disturbing in this regard.

9 So, access to health insurance and
10 medical care are important, they're not the same
11 as health and for me, actually the most critical,
12 imperative to control health spending is to free
13 up resources that would be much better devoted to
14 education and public health and other social
15 services if we actually want to get healthy.

16 So, my final point is what I call a
17 lesson from Chicken Little. So, and this is the
18 point that it's hard to find ways to control
19 health spending and it's, there's a huge gap
20 between what government officials and health
21 policy experts and consumers think about how
22 urgent it is to do that.

23 It is, and I think in fact Commissioner
24 Murphy actually made this point very early, well

1 and earlier this morning, most people with higher
2 incomes, which I imagine probably includes most of
3 us in this room, unless we work in this field we
4 don't necessarily see rising costs as a threat to
5 our own access, so, the issue of controlling costs
6 probably not in our personal lives, maybe has not
7 as much salience as it does for many other people.

8 In fact, I think as Commissioner Murphy
9 said is the downside to this, but the point here
10 that I want to make is I think for too long we've
11 deluded ourselves that there are ways to control
12 costs that don't involve sacrifice, that don't
13 involve fighting, that don't involve hard choices,
14 and some of the things that have recently been
15 well talked about, ways to control costs.

16 So, I think they're important and I would
17 put on this list, you know, eliminating waste and
18 a lot of this talk about public reporting,
19 administrative simplification, even Health HIT,
20 all of these things are really important and I
21 think we need to make investments in all of these
22 things, but to me more to include the quality than
23 to control costs because I don't think that any of
24 these things are going to be the way to control

1 costs.

2 I commend Commissioner Morales and his
3 staff, commissioned a very good report by the Rand
4 Corporation which is really an example of how many
5 of these things that are getting a lot of focus,
6 while they're very good to improve quality, it
7 probably won't actually help us to control costs.

8 So, instead controlling costs is going to
9 involve hard choices and political leadership,
10 including less revenue growth and income for some
11 providers, lower revenues, less profitability for
12 health plans and probably less and different care
13 for those of us who are consumers.

14 If you're as old as I am and maybe only
15 Rob has been around this issue as long as I have,
16 but since he's the only other one who has gray
17 hair, it really feels like testifying on the need
18 to control health care costs, you feel like
19 Chicken Little, and for those of you who haven't
20 read Chicken Little as recently as I have, Chicken
21 Little was frantic to warn the king that the sky
22 was falling and only an acorn was falling on his
23 head, and that's what most of us remember about
24 the tale of Chicken Little.

1 But to me the real moral of the Chicken
2 Little story is a different one and it's really
3 quite appropriate here, the moral of Chicken
4 Little to me is do not be afraid and don't be a
5 chicken, and I think we're at a moment in time
6 when maybe the political forces have aligned and
7 we're showing a readiness to attack this problem
8 in a new and different way.

9 For some of us it's because we want to
10 sustain the progress we've made on health reform,
11 for other people it's for actual reform, for
12 others it may be the only silver lining we can
13 find in the fact that the economy is so terrible.

14 So, I really urge us to heed both the
15 wisdom of Chicken Little and also it's actually
16 the wisdom of Stanford economist, Paul Romer, so,
17 he said a crisis is a terrible thing to waste.

18 So, I actually think we know what many of
19 the things we need to do to control health care
20 costs are, so, we really do know the health care
21 version of Inky, Blinky, Pinky and Clyde, and I
22 think we shouldn't waste the opportunity to do
23 something big and bold and effective in
24 controlling health care costs.

1 I would say consumers can't afford any
2 more delays in doing what needs to be done, so, my
3 fourth point is just let's not be chickens.

4 MR. AUERBACH: So, Dean Turnbull gets
5 special credit for weaving in both Pac Man and
6 Chicken Little into this discussion, thank you
7 very much for that. And now I'd like to introduce
8 Cheri Andes, Cheri is the lead organizer for the
9 Greater Boston Interfaith Organization, Cheri.

10 MS. ANDES: Thank you. For those of
11 you who don't know, Greater Boston Interfaith
12 Organization, GBIO, is an organization of
13 fifty-five other organizations, churches,
14 synagogues, mosques, unions, community development
15 corporations and some other creative institutions
16 that come together to work on public policy
17 issues, issues of justice, issues that our various
18 constituents can agree are critical to the 55,000
19 people that our organization represents and we
20 were proud and honored and excited to be partners
21 with almost everybody, everybody on this panel,
22 not everybody, everybody on this panel.

23 MR. AUERBACH: We'll talk later.
24

1 MS. ANDES: In helping to bring
2 health reform to Massachusetts and in helping to
3 implement health reform in a way that we felt
4 would benefit our members and the society as a
5 whole.

6 So, we're here today because we believe
7 that health care costs like health care access is
8 a justice issue. There's general consensus and I
9 think we've heard it today among policy makers and
10 consumers at large that as Nancy said, health care
11 costs are growing well beyond the overall rate of
12 inflation and people's incomes, three to four
13 times the rate of wages and health care costs in
14 Massachusetts are among the highest in the nation
15 and actually the world.

16 The consensus around that, GBIO believes
17 that this trend of out of control health care
18 costs is in fact a moral issue, is in fact a
19 justice issue and one that needs to be addressed
20 out of that, that belief system.

21 We believe that out of control health
22 care costs threaten the viability of Medicare and
23 Medicaid to meet the entitlement needs of those
24 groups, that's a justice issue. Rising health

1 care costs mean that employers instead of giving
2 wage increases have to dedicate these labor
3 related resources to paying health insurance
4 premiums instead, so, people aren't getting the
5 kind of wage increases that they need to maintain,
6 sustain themselves in this new economy, that's a
7 justice issue.

8 The cost rises leads to government
9 needing to scale back its payments to providers
10 making such patients less desirable to be cared
11 for by the doctors, so, people, especially
12 Medicaid folks, have difficulty obtaining
13 specialty care because no one will see them,
14 that's a justice issue.

15 Providers because of the fee for service
16 model are pressured to see too many patients in
17 one day which can and does lead to suboptimal
18 care, that's a justice issue. Access gains will
19 be eroded.

20 We worry about the erosion of the
21 individual mandate, and we also worry about the
22 erosion of the gains in access as costs go up,
23 we're not going to be able to afford to subsidize
24 so many or to maintain the benefit packages or

1 people will be cut from the rolls. Just look
2 what's happening with dental care whenever we have
3 a budget crisis, so, access will be eroded if we
4 don't get health care under control and John
5 Kingsdale is constantly reminding us of that.

6 And finally, for these reasons, GBIO
7 believes that the administration and the
8 legislature must act and act immediately to reign
9 in these costs.

10 We advocate a comprehensive approach
11 focused not just on providers which seems to be
12 where the current conversation in the political
13 arena has been focused but also on insurers,
14 administrators and pharmaceutical suppliers.

15 At this time we'd offer four specific
16 recommendations, hold insurers accountable to
17 reasonable premium increases, specifically we
18 support Governor Patrick's attempts to hold
19 insurance premium increases to one and a half
20 times for medical inflation rates for the upcoming
21 year.

22 No. 2, reform the way providers are paid
23 such that docs and hospital's recruits are
24 incentivized to provide high quality care but

1 neither too much nor too little based on patient
2 needs. Specifically, we support an all care
3 reform as recommended by the Special Commissioner
4 and we support the payment reform ten patient
5 priorities promoted by Health Care for All and
6 Massachusetts Campaign for Better Care.

7 No. 3, like Health Care for All's
8 testimony, like my friend Nancy's testimony, we
9 believe that public health and prevention will
10 have cost savings as well as improve the health
11 and quality of life. I don't need to say more
12 than that, public health is public health is
13 public health.

14 Finally, we believe that consumers are
15 the heart of the care system and must have a
16 strong voice in the governing of containment
17 reform spending. Consumers should be represented
18 on any governmental entity as well as the
19 governing of any ACO's or any payment
20 intermediaries.

21 I want to thank Commissioner Auerbach for
22 sharing this panel, Commissioner Morales for
23 organizing it and doing so in such a thoughtful
24 way that consumers didn't have to stand in line

1 all day to testify, so, appreciation is there,
2 thank you.

3 MR. AUERBACH: Thank you, Cheri, and
4 our final speaker on the panel will be Rob
5 Restuccia, Rob is the executive director of
6 Community Catalyst, Rob.

7 MR. RESTUCCIA: I want to thank
8 Commissioner Auerbach, Morales, Murphy and
9 Attorney General Coakley for this panel.

10 Nancy referred to my gray hair, I'm
11 perhaps one of the few people here who can recite
12 all of the hospital reimbursement laws from 1980
13 to now starting with Chapter 372 in 1982.

14 I think it's important to note that
15 Chapter 372 was legislation that was formulated by
16 a group of business leaders that came together in
17 1980 concerned about hospital costs and they held
18 private meetings at the business roundtable, they
19 developed legislation and brought it to the
20 legislature and passed the legislature without
21 debate and without dissent and there was no
22 consumer representation.

23 So, the change today is actually fairly
24 dramatic that there is a consumer voice organized

1 in this way and I think it's particularly
2 complimentary to the state and to the
3 commissioners and to the Attorney General and
4 Governor to hold this meeting.

5 I'm executive director of Community
6 Catalyst, a national nonprofit organization
7 working to ensure that consumers have a strong
8 voice in reforming the health care system.

9 Community Catalyst works in forty-one
10 different states and working together with those
11 organizations we also run campaigns to address
12 some of the serious problems in the health care
13 system.

14 Some of you may be familiar with the
15 Prescription Project which we partnered with
16 Health Care for All that addresses the issues of
17 drug company abuses to prescribers and with Health
18 Care for All partnering resulted in the successful
19 passage of Chapter 305 and we are very thankful to
20 the Commissioner of Public Health and his
21 department in order to move forward on that.

22 This year we're partnering again with
23 Health Care for All to address another serious
24 issue in the health care system, the failure to

1 provide high quality coordinated care to our most
2 vulnerable populations. Nationally people with
3 multiple health problems make the heaviest use of
4 the system at the highest cost but with the
5 poorest outcomes.

6 On the average the older adult with
7 multiple chronic conditions makes thirty-seven
8 visits to fourteen different doctors who prescribe
9 fifty different separate prescriptions in one
10 year.

11 Many of these patients are hospitalized
12 for conditions that could be prevented, they're
13 discharged from the hospital without adequate
14 planning and then readmitted often within a month.

15 So, under the current system there are
16 few incentives to address these problems, so,
17 providers are often challenged to coordinate the
18 care for the sickest patients.

19 Along with our national partners
20 Community Catalyst is working at a state and
21 federal level to develop and implement new payment
22 and system models. We believe that realigning the
23 payment system can lead to improved quality, lower
24 cost and provide appropriate structures that are

1 in place.

2 They include standards for care
3 coordination, provider access, accountability,
4 transparency and consumer involvement in the
5 development of care plans and Community Catalyst
6 is working in six different states on a campaign
7 including Massachusetts to promote state action.

8 There's a lot of work that needs to be
9 done here. In Massachusetts while the health care
10 system ranks high on many measures, according to
11 the 2009 Commonwealth Fund score card for health
12 care performance, Massachusetts has the third
13 highest reimbursement for Medicare enrollee of any
14 patient of any state.

15 Despite this enormous expenditure
16 Massachusetts ranks thirty-ninth in percentage of
17 admissions for ambulatory care sensitive
18 conditions, and thirty-seventh in percentage of
19 thirty-day hospital readmissions.

20 In prevention Massachusetts ranks
21 slightly higher but is still lower on many
22 measures. While state action is important it's
23 clear it's not sufficient. Federal action on
24 payment and delivery reform is critical to making

1 the whole system responsive to the needs of
2 consumers.

3 The health care reform legislation now
4 pending in Congress contains a number of important
5 provisions that will make the job here in
6 Massachusetts much easier including creating a
7 center for Medicare and Medicaid innovation,
8 strengthening the integration of Medicare and
9 Medicaid through the creation of federal
10 coordination care office, experimenting with
11 payment reforms that move us away from a fee for
12 service model starting with Medicare and pilot
13 projects around accountable care organizations.

14 We are optimistic about national health
15 reform and I think the next few days will tell us
16 where we're going on that but we recognize in
17 Massachusetts more needs to be done.

18 Massachusetts has been sort of a leader
19 in so many issues around health reform, we have
20 never addressed the issue of cost containment
21 effectively. I think as the previous speakers
22 have said, unless we deal with the issues of cost
23 and quality, our access to reform is going to be
24 threatened, thank you.

1 MR. AUERBACH: Thanks to each of you
2 for terrific presentations and you've heard with
3 earlier speakers and you've heard with other
4 panelists a lot of speculation about what can
5 motivate consumers and patients and how can they
6 be drawn into this debate about what kind of an
7 impact cost has on care.

8 Maybe I'd like to start by asking you
9 your organization's experience with some of the
10 notions of cost sharing or increase in cost
11 sharing.

12 We've seen from some of the Division
13 reports there is a trend upward in terms of cost
14 sharing among consumers or patients, either
15 through premiums, deductibles or larger
16 percentages of their premiums or copays or
17 deductibles.

18 I know that you all, and you have
19 mentioned already some of what you have seen, so,
20 maybe the question I would start by saying is are
21 there particular subpopulations that you're
22 working with where you're seeing there's unusual
23 vulnerability or consequences of an increase in
24 terms of cost sharing for consumers or patients?

1 MS. BANDA: Commissioner, for the
2 older population there's been a lot of research
3 that shows that if you increase cost sharing
4 especially as to copays and deductibles, people
5 stop taking their medications and when people stop
6 taking their medications, especially people with
7 chronic conditions, they just get sick again, they
8 get sick again, they need to access more expensive
9 care.

10 So, increasing cost sharing in our
11 opinion especially on low income populations and
12 from our perspective older populations is just
13 economically very short cited and is going to put
14 us all deeper in the hole than we already are.

15 MR. AUERBACH: Okay.

16 MS. SLEMMER: We've seen similar
17 trends, we hear from people on our help line every
18 day who are making just beyond 300 percent of the
19 federal poverty level and when you shift
20 additional cost to them it really prices care
21 beyond their reach and then we're faced with these
22 horrible anecdotes about people who now need
23 access to the system but can't afford it.

24 So, we see it as short cited and really a

1 bad trend for consumers and then we make referrals
2 to HLA because medical debt goes and makes, people
3 make choices that we would not want them to make.

4 MR. AUERBACH: Matt, would you say
5 you're seeing its disproportionate effect?

6 MR. SELIG: Well, I would say that it
7 is important to keep your eye on one area and
8 that's, there's cost sharing in that people sign
9 up for a health plan, they know what the copay is,
10 they know what the deductible is, they know what
11 the coinsurance is, but even after that there is,
12 there's still cost sharing, additional cost
13 sharing that's added and the types of things that
14 we see are people who enrolled in health plans and
15 their providers will try to get prior
16 authorization, you know, particularly for
17 situations like mental health care, and people
18 will have that their providers ask their insurers
19 for mental health care, and in many cases the
20 authorization for payment process is just so
21 overbearing that really payment is not available
22 and it ends up being, you know, additional forced
23 cost sharing for the consumer or sometimes the
24 provider who will just eat the cost, so, we see

1 that a lot.

2 And so, I think it's very important to
3 keep in mind that there really is much more cost
4 sharing to be seen out there besides what you
5 might see in any particular health plan that
6 somebody signs up for, but there's all sorts of
7 other costs and an example for that that I just
8 gave you is people with mental illness in
9 particular increasing health coverage for
10 particular services but the coverage really isn't
11 there, and even though it is maybe in their health
12 plan but in fact it is not accessible.

13 MR. AUERBACH: Thanks.

14 MS. TURNBULL: You're not going to
15 let me answer this one?

16 MR. AUERBACH: Please do, any one you
17 want to answer you can.

18 MS. TURNBULL: No, I just want to see
19 if I can just make a couple of points about this
20 one, consumer cost sharing is generally structured
21 at the moment as quite regressive and hits lower
22 income people.

23 I always say I'll take it more seriously
24 when a CEO of some company proposes that they have

1 a 2 million dollar deductible to make them more
2 cost conscious.

3 I think we also have to I think think
4 about where cost sharing can and can't be an
5 appropriate incentive for people to change their
6 behavior, so, we have seen some examples, for
7 example, tiered drug copayments where it's been
8 quite effective and that's because we actually
9 have what economists would call perfectly
10 substitutable goods, but for lots of things and
11 particularly things that are particularly
12 expensive I think there are two areas, one is one
13 can imagine, you know, being taken in an ambulance
14 for some care you needed in an emergency, and I
15 guess now we could pull out the AGO report and see
16 which hospital might be more cost effective but
17 that's just not really very reasonable, and we
18 also know that we have dominant provider systems
19 in many parts of the state and I think several of
20 the research reports that people have talked about
21 today are that.

22 So, and the last point I'd make is U.S.
23 consumers actually already pay much more out of
24 pocket than consumers in any other country for

1 their health care, so, you'd expect we might
2 already be more cost conscious than other people,
3 so, I think it suggests there are other strategies
4 that we probably need to pursue.

5 MR. RESTUCCIA: I think to focus
6 particularly on those with chronic diseases, the
7 average person with multiple chronic diseases gets
8 fifty prescriptions a year, one of the areas we're
9 looking at and we need to look at the behavior of
10 insurance companies as part of this is with asthma
11 medications, for example, because we know that the
12 inhalers now are propelled by new propellents, so,
13 it's all brand name.

14 So, folks who have asthma are paying
15 oftentimes \$40 for an inhaler which they need once
16 a month and if you think about a family with a
17 couple of kids with asthma what the cost of that
18 is.

19 You wonder in terms of the downside in
20 terms of the hospitalizations that result from the
21 failure of filling those or affording those
22 prescriptions, so, I think in particular when you
23 start thinking about folks with chronic diseases,
24 you really need to think twice about how

1 copayments and deductibles impact.

2 MS. SLEMMER: Can I just quickly say?

3 MR. AUERBACH: Oh, sure.

4 MS. SLEMMER: Health Care for All,
5 one of the things that we see some opportunity in
6 health care reform is the flip side of additional
7 copays and that would be to drop copays for
8 preventive care because we know that it's cost
9 effective and will drive people to change
10 behavior.

11 MS. TURNBULL: Right, in fact, we
12 know that that's what some more forward looking
13 employers are doing now.

14 MR. AUERBACH: Why don't you clarify,
15 examples of preventive care that you would include
16 in that category.

17 MS. BANDA: Screenings.

18 MR. AUERBACH: So, screenings,
19 testing, screening for cancer, high blood
20 pressure, diabetes, those type things.

21 MS. TURNBULL: Oh, sure, waiving
22 copayments for the types of drugs that Rob was
23 talking about, the people with chronic illness,
24 asthma, diabetes where we know that actually

1 compliance makes a huge difference in terms of
2 preventing more expensive care.

3 MR. AUERBACH: So, let's talk about
4 some of the other strategies that might work. You
5 know, we heard from the AGO report that there is a
6 growing, there seems to be an increase in terms of
7 the utilization of more expensive hospitals,
8 particularly hospitals versus lower cost hospitals
9 even though the quality didn't seem to be
10 correlated with quality, what did you make of
11 that?

12 How do you think about that in terms, do
13 you think about that, for example, from both the
14 perspective of how patients or consumers are
15 making decisions about which hospitals to go to
16 and do you think that we could recommend
17 approaches that might discourage the use of higher
18 cost institutions where a lower cost institution
19 was in the same general area, neighborhood,
20 thoughts about that particular approach, Nancy.

21 MS. TURNBULL: All right, some
22 approaches I think would be more supportable to me
23 than others, you know, a couple of the ones people
24 are talking about at the moment are tiered

1 copayments, pay a higher copayment if you go to a
2 more expensive hospital and again, I think
3 particularly in certain parts of the state where
4 you don't have any choice of hospital, that's not
5 a very appropriate strategy.

6 An approach which I've always liked
7 better and which was attempted here about ten
8 years ago but met with I think some of the
9 resistance of some of the provider forces that we
10 talked about earlier, was a model that was born in
11 Minnesota, it was called Patient Choice, and there
12 consumers were given a choice at the point at
13 which they made a decision about what health plan
14 they were joining, they had to pick a delivery
15 system, the delivery systems were tiered on price
16 and on quality.

17 And so, the incentive that you faced was
18 you paid more if you picked a more expensive
19 delivery system and that always seemed to me a
20 more appropriate way to me because it let people
21 pick at the time that they picked their insurance
22 but not at the time when they needed a particular
23 test or medical procedure, so, I like that
24 approach very much and would recommend that for

1 people to think about.

2 MR. RESTUCCIA: And I guess from my
3 perspective it's hard to know whether the genie's
4 out of the bottle but we've encouraged and created
5 a competitive health care system in which we
6 instead of creating a system, a system that has a
7 head, we have the competition.

8 And so, we're seeing institutions moving
9 in the direction of creating profitable services
10 and then advertising them heavily and then
11 complaining that consumers are responding to that
12 and we've created the incentives to do that, you
13 know, it is, we have our priorities backwards.

14 I think of a system that was developed
15 around neonatal intensive care that DPH developed
16 twenty-five years ago, there's level 1, 2 and 3
17 and there's a system setup, why can't we do that
18 in general and create some sort of rational system
19 with allocation of resources.

20 We've allowed the determination of need
21 really to become much easier to get, and you know,
22 it's driven more by politics than by a rational
23 system consideration.

24 So, to some extent I think we just need

1 to go back and have a system with a head that has
2 some planning in it and stop the competitive
3 environment that we've had for, you know, the past
4 now, what is it, Nancy.

5 MS. TURNBULL: Too long.

6 MR. RESTUCCIA: 1991 maybe before.

7 MS. TURNBULL: No, I think that's
8 right, I think this culture of sort of blaming the
9 consumer as if we're choosing to go to these very
10 expensive places, it does have it backwards and I
11 think the important public policy question for
12 state officials and legislators is do we believe
13 that now that we understand more about the system,
14 can it be recalibrated through private
15 negotiations between payers and providers or do we
16 in fact need to have, as Rob is suggesting which I
17 agree with personally, more of a head to the
18 system because I don't think given what the
19 configuration of the delivery system looks like in
20 parts of the state that a recalibration is
21 possible, that that's significant reengagement by
22 government.

23 MR. AUERBACH: Just so I think I hear
24 you, you're both saying that part of the reason

1 that patients or consumers may be choosing those
2 facilities that are higher costs is because of
3 advertising, promotion of the facility through
4 marketing, that's, you think that's a significant
5 factor in terms of that?

6 MS. TURNBULL: Well, I think that,
7 yes, I do think that's a factor and in fact I
8 think we need to interject in here the important
9 role that physicians play in determining where we
10 go to the hospital and determining what the growth
11 in the number of physicians who are affiliated
12 with particular systems, the power that that has
13 given to those systems, the market leverage that
14 the AGO report and others show, so, I think that's
15 an important factor.

16 MR. AUERBACH: Cheri.

17 MS. ANDES: Yeah, I think that a lot
18 of times in the political debate, you know, we get
19 caught, we get caught thinking that providers only
20 care about pay and that consumers only care about
21 choice and the political access kind of goes in
22 and around those two assumptions, and I think that
23 consumers do care about choice but they also care
24 about quality and they also care about cost and I

1 think we're getting to a place now with the
2 availability, you know, with the information that
3 the AG's providing, with the availability of more
4 transparency and the ability to objectively
5 compare institutions that I think we can see over
6 the next ten years a pretty radical shift in
7 consumer behavior that's more rationally driven if
8 we give consumers the tools that they need, and I
9 think Nancy's suggestion about upfront having
10 folks choose whether they're called limited
11 networks, or you know, particular networks, tied
12 to their ability to research those networks and
13 tied to their ability to cost out those networks
14 is a fabulous idea.

15 MR. AUERBACH: So, just to stick on
16 that topic for a second, the topic of
17 transparency, I think a lot of you have spoken to
18 the importance of transparency about costs and
19 quality with regard to a wide variety of different
20 health care institutions, I think it's my
21 impression the jury's out about how, how even
22 accessible information is used and often people
23 don't have the ability to access that information
24 easily or weigh the different findings, what is

1 your sense about how, what can be done in order to
2 make transparency really a major driver in terms
3 of some of the decision making that patients and
4 consumers are making with regard to where so that
5 we think about quality as well as cost.

6 You started to speak about that, Cheri, I
7 don't know if you have additional thoughts.

8 MR. SELIG: I mean I would just say,
9 you know, anecdotally when I think about the
10 clients that come to our office, when they talk
11 about where they're going to seek their health
12 care, they're talking about where they can go,
13 where there's transportation provided, a lot of
14 them don't have cars, they may not have facilities
15 in their area.

16 So, that's, you know, going to be
17 probably at the top of their list in where they're
18 going to go for care and they also want providers
19 who know about their health issues, people who
20 have chronic conditions especially they want to
21 know their health background, and you know, many
22 people are flexible but I would think that they're
23 going to want to stick with providers they can get
24 to and providers who know about their health

1 situation and can provide the care that they need.

2 MR. AUERBACH: Yes, Deborah Banda.

3 MS. BANDA: Yes, thank you, I think
4 we've made a lot of progress in the state on
5 providing some of the tools that are designed to
6 help consumers better navigate the health care
7 system and to make educated choices, that said,
8 from our perspective a lot of those tools are
9 still pretty much designed for a medical audience
10 and not for the consumer audience and they still
11 have a long way to go for them to be truly useful
12 for the average consumer, you know, not the person
13 whose got a PhD in public health or whose
14 grandfather was a doctor or whatever, but just the
15 average caring person who wants to go and figure
16 out how to get the best health care for the best
17 cost for their family.

18 And again, I know there's a lot of effort
19 made and there has been progress, but from what
20 we've seen those sites aren't really designed for
21 consumers even though they say they are.

22 MR. O'BRIEN: And just to follow-up
23 on that and I'll try to not work in Chicken Little
24 and Pac Man.

1 MS. TURNBULL: Go for another
2 children's book.

3 MR. O'BRIEN: Nancy mentioned social
4 determinants of health and education being the
5 first one mentioned, I think you're talking about
6 the same thing and how do we weave into the health
7 care system, the employer based health care system
8 education and approach that addresses those other
9 social determinants of health.

10 We've heard from EMC, it isn't just one
11 approach of health medical management but some of
12 these other pieces and I want to get a sense from
13 you how do we get consumers engaged.

14 MS. SLEMMER: I think that's
15 critically important and I would invite us to
16 think in addition to educational, it's also
17 cultural confidence.

18 I think making sure that we have the
19 information available and accessible for anyone
20 who is trying to be able to make informed
21 decisions is critically important as the
22 foundation for consumer engagement, and as I say,
23 we feel strongly that if you have an informed
24 consumer, I thought that EMC story was very

1 interesting because she has correlated these
2 investments in lower health care costs and better
3 health outcomes.

4 So, you know, at Health Care for All we
5 struggle with that, one of the things that we've
6 talked about is moving towards, looking to
7 incentivize shared decision making so that the
8 patient again is really at the center of the
9 serious decisions they have made and has an
10 opportunity to make choices that will better
11 reflect what their values and expectations are.

12 And I think it's important in a variety
13 of settings, I think because you're talking about
14 chronic disease management, it's pivotally
15 important and again, offers some real
16 opportunities for savings.

17 MR. AUERBACH: Yes.

18 MS. TURNBULL: I guess I would say a
19 couple of things, you know, I think the issue is
20 what do we want consumers to be engaged to do and
21 to me EMC's program, I liked it very much, since I
22 know about it because it seems as if it tries to
23 engage people to engage in healthier behaviors and
24 to give them tools that are not punitive but that

1 are encouraging to be able to do that.

2 So, I think that's an important role
3 which employer programs can play. I think where
4 we get into difficult grounds is how can we
5 appropriately use price sensitivity as a tool for
6 changing consumer behavior and to me the tensions
7 there are do we try to make consumers price
8 sensitive at the point at which they go to get
9 medical care, a particular service which are often
10 very vulnerable, anxiety produced at times or
11 sometimes they don't have a choice of provider and
12 it's difficult to make good decisions of anyone
13 whose been in that situation should know or do we
14 try to make them price sensitive by getting them
15 to pick and agree to get their care from a
16 delivery, an organized delivery system that is
17 good value and produces high quality and give them
18 the information to let them make discernments
19 among systems on those credentials and not just
20 every time they go to get care and I think many
21 people think that what could be exciting out of
22 payment reform and what could be exciting out of
23 our increased ability to actually give consumers
24 better and better quality information is that we

1 could structure a system in which consumers can
2 appropriately make those types of decisions, you
3 know, not to say if you go to this hospital, you
4 have a \$500 deductible and this one you have 200,
5 because at the end of the day the deductibles can
6 really make most people price sensitive given how
7 much the hospital admission costs and wouldn't be
8 things that I don't think any of us would want.

9 MR. AUERBACH: So, let me ask a
10 related question, one that was raised and that
11 came from one of the audience, and that is the use
12 of community health workers as part of the
13 clinical team and maybe being reimbursed for their
14 activities, community health workers being not
15 licensed health care professionals at this point,
16 maybe down the road but more community members who
17 may be from the same racial, ethnic, linguistic
18 group of the patient population, thoughts about
19 that, the use of those workers and whether or not
20 those services should be thought of as something
21 to pay for maybe under global payment, global
22 reimbursement, Rob?

23 MR. RESTUCCIA: I think the answer is
24 yes, I think part of the cost quality equation

1 here is to really change the workforce of a new
2 delivery system and community health workers are
3 an integral part of that.

4 I'm on the board, Nancy and I are on the
5 board of Commonwealth Care Alliance which is
6 working to care for the disabled population in
7 Cambridge and they've just hired community health
8 workers as an integral part of their delivery
9 system and the idea is you're going to keep people
10 out of the hospital as much as possible as a
11 result saving money.

12 I think that community health workers in
13 so many ways have demonstrated their effectiveness
14 not just Massachusetts but across the country and
15 across the world, you know, the fact that we don't
16 really recognize them as a profession and an
17 integral part, I think it's important to think
18 about the training and integrating them into the
19 delivery system. How can you have care
20 coordination without it.

21 I think actually in Springfield it's like
22 one of the key places in the country where
23 community health workers has been demonstrated to
24 be a really effective model and the health centers

1 and hospitals have all worked really
2 collaboratively to make that work. Thinking about
3 how to integrate that into the system,
4 reimbursement I think is incumbent on us moving
5 forward.

6 MS. TURNBULL: Yeah, that's the
7 exciting thing about global payment, dare I use
8 the word capitated systems, it unleashes the
9 creativity of providers to think about what are
10 better and cheaper and higher quality ways to do
11 those.

12 MR. AUERBACH: Let me ask the flip
13 side of that just for a second because we have a
14 little bit of time, you heard a number of people
15 say well, maybe a way to effect cost or reduce
16 cost is to have some sort of added cost to health
17 care premiums, if you're a smoker or if you're
18 overweight and that would create, you know, the
19 motivation for patients and consumers to take more
20 control of their health and they would be
21 healthier people, and therefore, the cost would go
22 down, reaction to those proposals.

23 MS. ANDES: Well, I mean my gut
24 reaction is it's incredibly regressive way of

1 coming at funding our health care system. We
2 already do it to a certain degree with the
3 regressive taxes, the tobacco tax which we
4 actually support, and you know, various other sin
5 taxes, alcohol tax, but it seems to me that to
6 fundamentally punish people for being ill, to
7 punish people for an addiction, to punish people
8 for, you know, obesity is, just strikes me as
9 fundamentally wrong.

10 MR. AUERBACH: Other thoughts?

11 MS. BANDA: Amy and I indicated
12 earlier there's been some evidence that shows if
13 you actually do reduce the cost sharing on those
14 populations, it promotes people to more closely
15 follow the doctor's orders and that leads to
16 better health, so, you know, punishing I guess is
17 a moral issue here too but punishing folks with
18 medical.

19 MS. TURNBULL: I mean I think on
20 moral grounds and I agree with those comments, I
21 don't think there's any evidence those are
22 effective strategies in terms of preventing, in
23 getting people to stop smoking, or you know, with
24 it Harvard could just charge me more on my health

1 insurance but I don't think there's any evidence
2 that those actually work.

3 MR. AUERBACH: So, maybe there's just
4 a final question then is what would work, what
5 would work as a way of, particularly on that issue
6 of encouraging healthier behaviors, are there
7 things that can be built into the system of
8 reimbursement that would in fact encourage, you
9 know, people to give up smoking, people to eat
10 healthier foods, to, you know, improve some of
11 their behaviors so that their risks would be less.

12 MS. TURNBULL: Well, I think on the
13 smoking front, and you know, you and your
14 colleagues at the DPH have documented this well,
15 we know that the inclusion in health insurance
16 benefits of robust smoking cessation programs and
17 smoking cessation drugs and a variety of other
18 interventions actually are proven strategies, so,
19 those are ones.

20 MR. AUERBACH: As covered benefits,
21 you're saying as covered benefits.

22 MS. TURNBULL: As covered benefits,
23 you know, I don't know of an intervention that's
24 been proven to be effective as an add on to health

1 insurance benefits, that's a good strategy on
2 obesity, I mean I think that's a very
3 multifactoral program which needs this whole
4 system wide approach in health insurance to really
5 be an important component of that, I have not seen
6 any evidence on it.

7 MR. AUERBACH: Thanks.

8 MS. ANDES: And I would just support,
9 you know, going back to the idea of community
10 health workers, going back to an idea that I think
11 used to be more popular than it is now which is
12 school based health clinics, going back to an idea
13 of what the faith community talks about parish
14 nurses which has been a very popular and very
15 successful model inside congregations for starting
16 walking clubs and for managing hypertension and
17 some of those things that don't need high level
18 care, don't need even a doctor's visit.

19 So, rethinking how some of those things
20 can be delivered close to home where other
21 behaviors can be influenced and changed.

22 MS. TURNBULL: Perhaps on some of
23 those things we could fund it, you know, I mean
24 not directly through health insurance premiums but

1 in partnership with some of the organizations like
2 health insurance that would benefit from the
3 strategies which are more successful.

4 MR. AUERBACH: Any closing comments
5 anyone would like to make on a topic we haven't
6 touched on?

7 MS. SLEMMER: Well, there's an awful
8 lot of commentation going on currently about how
9 Chapter 58 has affected the state and our state
10 finances and we feel strongly that this is, we
11 have not bankrupted the state, we have made this
12 investment and have benefited tremendously from
13 bringing 400,000 people into our health care
14 system and now it's really time to take the next
15 step of making sure that the care people are
16 accessing is both comprehensive, cost effective
17 and of the highest quality possible and we're very
18 optimistic that we'll be able to do that in the
19 next phase of health reform in Massachusetts.

20 MR. AUERBACH: Cheri.

21 MS. ANDES: I'll add one piece which
22 is that, you know, I said in my testimony that we
23 support the recommendations of the Special
24 Commission, we were disheartened that the Special

1 Commission didn't include the consumers on its
2 make up and I think that, you know, part of the
3 success of Chapter 58 and putting together a broad
4 based coalition across the Commonwealth that could
5 support not just health reform but the complicated
6 implications of health reform which required
7 enormous political consensus had everything to do
8 with having groups like this at the table and we
9 think that the question of payment reform and
10 cost, bending the cost trends is equally
11 important, equally complex and will require an
12 equal effort on the part of consumers and
13 inclusion on the part of consumers and advocates
14 to make a difference in that arena.

15 MR. RESTUCCIA: And just a final
16 pitch, national reform hangs in the balance, it's
17 going to happen in the next few days or not, I
18 wouldn't make any assumptions about whether it's
19 going to pass or not or how your representative is
20 going to be voting.

21 So, if you are concerned about cost
22 issues and you don't want Massachusetts to be
23 alone in this, there are opportunities to call
24 your legislature.

1 MR. AUERBACH: Well, thanks to each
2 of you, these are great topics, I think clearly
3 you've illustrated the importance of having a
4 consumer voice at the table and many of these
5 topics I think we'll be continuing to talk about
6 in the coming months, so, please join me in
7 thanking all the members of the panel.

8 (The audience applauded.)

9 MR. MORALES: Thank you, Commissioner
10 Auerbach and to the distinguished panel, I thank
11 you as well and I want to conclude today's hearing
12 but I just I jotted down notes throughout the day
13 and I just want to include by just sort of
14 recapping some of the day's highlights but prior
15 to doing that I want to thank Attorney General
16 O'Brien, Lois, their team, Commissioner Murphy,
17 our panelists and especially my team who is here
18 today who has worked really hard and some of our
19 expert researchers, but I also want to thank you
20 who have sat here patiently and willing to listen
21 to today's testimony and discussion.

22 It's certainly a complex dilemma and one
23 that requires immediate attention, so, just to
24 sort of offer my thoughts, things that I've sort

1 of jotted down throughout the day as I've been
2 listening, first and foremost, I'm very encouraged
3 because Governor Patrick, Senate President Murray
4 and other state officials reminded us of the
5 extraordinary leadership and commitment that we
6 have from the administration, legislature to
7 tackle this difficult challenge and identify
8 strategies that will both provide immediate relief
9 to the residents and businesses but also to
10 develop actions for lasting meaningful change in
11 the Commonwealth's health care system.

12 No. 2, the Division's experts summarized
13 some of the key findings from our analysis, for
14 example, between 2006 and 2008 private spending
15 per member for health care in Massachusetts grew
16 by about 15 percent, more than 75 percent of the
17 growth occurred in outpatient hospital facilities
18 and physician and professional services and care
19 is being provided at more expensive settings over
20 time.

21 Interestingly enough, price, not
22 utilization virtually, is the single most
23 important factor fueling rising health care
24 spending. No. 3, the findings from the Division

1 of Insurance and the Office of the Attorney
2 General echoed some of the agency's findings, for
3 example, one area of particular concern and
4 opportunity is the wide variation in prices paid
5 by private health plan for the same service by
6 different providers, and in addition, the AG
7 succinctly showed that prices are correlated to
8 the market leverage and may not be correlated to
9 quality.

10 Also, Len Nichols reminded us of the dire
11 impact that rising health care costs will have on
12 our state and local economies if nothing is done
13 to mitigate health care cost growth immediately.

14 In the afternoon we heard from employers
15 of varying sizes about the impact of rising health
16 care costs have had on their ability to do
17 business, to hire workers and grow.

18 Our analysis highlighted the disparities
19 in the insurance market between different sized
20 employers and panelist testimony only further
21 conveyed that point.

22 We also heard from consumer groups about
23 the impact of costs on access to health care, the
24 need for better coordination of care and the

1 burden of rising premiums on individual and family
2 budgets during this economic time.

3 We also heard about the need to create
4 incentives for consumers and how and where they
5 access care and prioritize prevention and
6 wellness. Panelists also reminded us of the
7 benefits of prevention and about the value of
8 health care reform and insuring accident coverage
9 and urge us to address costs with the same sense
10 of urgency.

11 The goal of today was to help set the
12 stage for conversations on Thursday and Friday
13 that are more specific to the health care system,
14 what we're doing about cost and to develop long
15 term policy solutions, which by law the Division
16 is required to issue weeks after these hearings.

17 And so, we're going to continue this
18 dialog Thursday and Friday, we'll reconvene this
19 Thursday at 9 a.m., thanks again everybody.

20 (The audience applauded.)

21 (Whereupon, the hearing adjourned at
22 3:50 p.m.)

C E R T I F I C A T E

COMMONWEALTH OF MASSACHUSETTS
SUFFOLK, SS.

I, Julie A. Healey, Certified Shorthand
Reporter, Registered Professional Reporter, and
Notary Public in and for the Commonwealth of
Massachusetts, do hereby certify:

That the testimony that is hereinbefore
set forth is a true and accurate record of my
stenotype notes taken in the foregoing matter, to
the best of my knowledge, skill and ability.

IN WITNESS WHEREOF, I have hereunto set
my hand and Notarial Seal this 9th day of April,
2010.

Julie A. Healey
CSR, RPR
Notary Public

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Massachusetts Health Care Cost Trends Final Report

Appendix C.5c

Health Care Cost Trends Public Hearings

Transcript for Morning Session Thursday, March 18, 2010

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COMMONWEALTH OF MASSACHUSETTS

Executive Office of Health and Human
Services
Division of Health Care Finance and Policy

PUBLIC HEARING RE:

HEALTH CARE PROVIDER AND PAYER COSTS TRENDS

BEFORE: David Morales, Commissioner

Held at:

University of Massachusetts Boston
Joseph P. Healey Library
100 Morrissey Boulevard
Boston, Massachusetts 02125

Thursday, March 18, 2010
9:07 a.m.

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P R O C E E D I N G S

COMMISSIONER MORALES: Good morning. My name is David Morales. I am the Commissioner of the Division of Health Care Finance and Policy.

I am joined by a key partner here, Assistant Attorney General Lois Johnson. I will be joined later today by Commissioner Joe Murphy of the Division of Insurance.

Welcome, and thank you, again, for joining us today.

Today marks the second day of the Division's public hearings on Health Care Cost Trends.

For those of you that were not in attendance on Tuesday, I will take a few minutes to provide an overview of our goals for the hearings and to explain the general format.

As many of you know, Chapter 305 of the Acts of 2008 directed the Division to issue reports on health care costs and to then hold public hearings with key

1 stakeholders from the health care system to
2 help determine the best course forward with
3 action-oriented solutions.

4 These hearings are the culmination
5 of over a year's work of research in health
6 care cost growth in Massachusetts by the
7 Division of Health Care Finance and Policy,
8 the Office of the Attorney General, the
9 Division of Insurance and many others like
10 you.

11 Our collective efforts point to a
12 sense of urgent action on costs as well as
13 the obvious.

14 For example, we know Massachusetts'
15 health care system is a critical component
16 of the state's economy. Health care is the
17 state's top industry, the largest employer
18 of Massachusetts residents and accounts for
19 over 13 percent of its 365 billion dollar
20 gross state product.

21 The Commonwealth Fund ranks
22 Massachusetts 7th overall among states on
23 its states score card system which measures
24 health performance system. This success can

1 be partly attributed to a commitment to an
2 increase in enrollment in coverage as well
3 as supporting access to care for residents
4 without insurance.

5 Moreover, Massachusetts is
6 fortunate to have a strong provider network
7 which includes some of the best hospital
8 quality indicators and health insurers that
9 are consistently rated among the top 10 best
10 hospitals and plans in each category
11 nationwide.

12 At the same time we know urgent
13 action is essential. Massachusetts is
14 grappling with escalating health care costs
15 which are consuming a greater portion of the
16 economy and impacting wage growth.

17 On Tuesday we heard from experts
18 about key challenges faced by the
19 Massachusetts health care system -- price
20 variation, lack of coordination of care and
21 disparities in the insurance market between
22 different size employers. We heard about
23 the impact that rising costs will have on
24 our state and local economies if nothing is

1 done to mitigate the trend we are
2 experiencing both here and nationally.

3 We heard from employers of varying
4 sizes about the impact that rising health
5 care costs have had on their ability to do
6 business here and to hiring workers and to
7 grow.

8 We heard from consumers about the
9 impact of cost on access to health care, the
10 need for better coordination of care and the
11 stark urgency of addressing this issue now.

12 Today we will examine the factors
13 that contribute to high health care costs in
14 Massachusetts including the structure of the
15 health care system and the payment methods
16 currently used by our insurers.

17 Understanding these factors will
18 better prepare the Commonwealth to evaluate
19 and develop strategies that have the
20 potential to simultaneously mitigate cost
21 growth and improve quality.

22 Before we begin, I want to quickly
23 review today's agenda. We will start with a
24 presentation on creating the frame work for

1 high performing organizations by Doctor
2 Stephen Schoenbaum, the Director of the
3 Commission on High Performance Health
4 Systems at the Commonwealth Fund.

5 Next we will have a panel of
6 witnesses to discuss the Massachusetts
7 health care delivery system moderated by
8 Michael Bailit.

9 We will then break for a short 30
10 minute lunch. The cafeteria is located on
11 the first floor.

12 We will promptly begin at 1:00 p.m.
13 with a presentation by Paul Ginsburg,
14 President of the Center for Studying Health
15 System Change on pricing of services in the
16 health care market.

17 Lastly, we will have a panel of
18 witnesses discuss cost drivers moderated by
19 Nancy Turnbull.

20 I want you all to know that
21 panelists will be sworn in and will,
22 therefore, provide their testimony under
23 oath.

24 While the moderator will ask the

1 majority of questions, we may intervene at
2 the head panel at any point today.

3 As was the case Tuesday, I also
4 want to encourage you all in attendance to
5 engage in today's discussion. Members of my
6 team will pass out index cards and they are
7 also available at the registration table
8 should you need them. Please write any
9 questions that you may have for the
10 panelists and give them to members of my
11 team.

12 At the end of each panel, the
13 moderator will select certain questions and
14 ask them.

15 At this time I would like to ask
16 Doctor Stephen Schoenbaum with the
17 Commonwealth Fund to speak, but first Stan
18 Wallack.

19 PROFESSOR STANLEY WALLACK: Let
20 me just add to Commissioner's Morales'
21 comments about the work that the
22 Commonwealth Fund is doing on high
23 performing organizations and high performing
24 health care.

1 This is to me in any way one of the
2 most exiting things that is going on in the
3 foundation world with regards to a project.
4 It has really been -- it is cutting a new
5 path and new things and every year those of
6 us in academia or those of you who do
7 research get a note from the Commonwealth
8 Fund on how do you rate the Commonwealth
9 Fund -- and I probably shouldn't tell you
10 but -- and I do the checklist.

11 I go through the list when I do the
12 checklist and I rank the Commonwealth Fund
13 right at the very top and the reason I do is
14 because of what is going on with what you
15 are doing, Steve.

16 So I think it is great that you are
17 here and I appreciate that you have come
18 today.

19 DOCTOR STEPHEN SCHOENBAUM:

20 Thanks very much. It is very much like
21 coming home since I grew up here and was
22 here until 10 years ago.

23 Thank you, Commissioner Morales for
24 this opportunity to participate in this

1 hearing and I just should mention that the
2 Commonwealth Fund is a grant-making
3 foundation it has been in existence since
4 1918 and it has national scope but it is
5 based in New York City.

6 In 2005 the Fund's Board of
7 Directors approved our developing a
8 commission on high performance health system
9 and charging it with recommending policies
10 and practices that will move the
11 United States towards a higher performing
12 health care system that achieves better
13 access and improved quality, greater
14 efficiency and focuses particularly on the
15 most vulnerable due to income, minority
16 status, health or age. There are currently
17 17 members of the Commission. The Chairman
18 since its inception is James Mongan who is
19 former Chief Executive Officer of Partners
20 Health Care here in Boston. There are two
21 other current members of the Commission from
22 Massachusetts, Maureen Bisognano, the Chief
23 Operating Officer of the Institute for
24 Healthcare Improvement and Michael Chernew,

1 Professor of Health Economics at Harvard
2 Medical School.

3 For the first four years, Cleve
4 Killingsworth who then was Chairman and CEO
5 of Mass Blue Cross/Blue Shield was also the
6 Commissioner.

7 Early on, the Commission
8 established that the objective of health
9 care in a high performance health system is
10 to help everyone to the extent possible lead
11 long, healthy and productive lives.

12 It stated that a high performance
13 health system does this by providing access
14 to care for all, high quality health care,
15 efficient use of resources and relentless
16 system and workforce innovation and
17 improvement.

18 The Commission evaluated the
19 performance of the U.S. through national and
20 state score cards and the score cards
21 document that in each division -- in each
22 dimension of care, the average performance
23 across the United States is only about
24 two-thirds of achievable bench marks. The

1 bench marks that we use on the score card
2 are almost without exception based on
3 achieved performance, not on ideal
4 performance that one might say was the
5 theoretical level and this just illustrates
6 some of those dimensions and the fact that
7 the results have been fairly similar in two
8 separate measurements across the country.

9 There is also wide variation across
10 the country which you can imagine given,
11 knowing that the bench marks are about 30
12 percent higher than the average performance.
13 And this diagram which you probably can't
14 read but in fact all of these are available
15 on our website shows the point that
16 Commissioner Morales made which is that
17 Massachusetts' performance was very high.
18 It was 7th out of the 50 states and the
19 District of Columbia.

20 Like almost all of the states,
21 however, Massachusetts' performance did vary
22 by dimension.

23 Now not surprisingly given the
24 Commonwealth's landmark health care reform

1 law and its implementation, Massachusetts
2 ranked first in the country on access to
3 care.

4 It was fifth on prevention and
5 treatment, and sixth on healthy lives, and
6 seventh on equity and 33rd on avoidable
7 hospital use and costs.

8 Although it is fitting that the
9 principal subject of these hearings is
10 related to cost and cost is higher
11 throughout the United states than it is in
12 other countries, so it is an issue
13 nationally.

14 Massachusetts does rank near the
15 middle of states in per capita health
16 standing as a percentage of gross state
17 product and better than average in employer
18 premiums as a percentage of median household
19 incomes for persons under age 65.

20 In November of 2007 as the country
21 was beginning to prepare for the last
22 presidential election about two years after
23 the Commission was formed, it published a
24 report that laid out a "ambitious" agenda

1 for the next President. It defined a set of
2 five key strategies for achieving a high
3 performance health system in the United
4 States.

5 The first is to extend affordable
6 health insurance to all. The second is to a
7 line financial incentives to enhance value
8 and achieve savings. And the third is to
9 organize the health care system around the
10 patient to ensure that care is accessible
11 and coordinated. The fourth is to reach
12 current bench marks, remember that the
13 country is only performing about two-thirds,
14 and then continually raise performance for
15 high quality efficient care.

16 In short, that could be translated
17 as increasing accountability should be
18 ensured for quality and cost and the fifth
19 is to develop accountable leadership and
20 strong public private collaborations
21 throughout the health system.

22 Now in Massachusetts you have
23 extended health insurance and have the
24 lowest rates of uninsured in the country.

1 But the challenge now is to make it
2 sustainably affordable and I am almost
3 certain that that will require attention to
4 all of the other four strategies and because
5 there they are interrelated, it will require
6 addressing them together and not in
7 isolation from each other.

8 I would love to be able at this
9 point to give you a listing of high
10 performance delivery system organizations in
11 the United States and in Massachusetts --
12 ones that have demonstrated excellent
13 access, high quality, equitable care that
14 achieves excellent clinical and patient
15 experience outcomes and has costs that are
16 low in trending downwards year over year,
17 but I don't have a list of organizations
18 that meet all of those criteria. And the
19 U.S. lacks an agreed upon set of performance
20 criteria for health care organizations that
21 can be used to assess even just quality and
22 cost across all of the populations that they
23 serve. And I emphasize across all of the
24 populations. The measures we have cover

1 just part of the picture.

2 For instance, last summer the
3 Institute for Healthcare Improvement and the
4 Brookings Institution convened
5 representatives of 20 of the more than 300
6 hospital referral regions or HRRs from around
7 the country. They chose 20 of the HRRs that
8 have been shown by investigators at
9 Dartmouth Medical School to have some of the
10 lowest costs for comparable outcomes in the
11 country.

12 The choice of those communities as
13 exemplars of high performance however has
14 since been criticized as representing
15 examination of only limited outcomes and
16 only Medicare data on costs.

17 Although that is undeniably
18 important for Medicare and Medicare is the
19 single largest payer for health care in the
20 United States, and it needs to know who
21 performs best for its beneficiaries and how
22 they do it, I believe and this is a personal
23 belief that a major national and state
24 priority should be obtaining an agreement on

1 a standard set of quality and cost measures
2 that can be collected across all populations
3 and all payers.

4 There will be exemplars out there
5 that will meet this criteria and we do need
6 to find them and learn from them. And to
7 develop so called accountable care
8 organizations, and recognize their
9 achievements it is going to be essential
10 to reach general agreement on how their
11 performance will be measured, essentially
12 what they are going to be accountable for.

13 Although there is a lot that we
14 don't know about performance, let me start
15 with what we do now.

16 First, as is illustrated in the
17 next two exhibits and I am told that these
18 will be posted so I am not going to read
19 them or dwell on them at this point, but as
20 they show, we know that organization of care
21 is a necessary condition for higher quality
22 and cost performance. It is not a
23 sufficient condition.

24 We also know that integration of

1 care within health care settings and across
2 settings -- so across transitions in care is
3 important for achieving higher quality and
4 efficiency of care. And a key element for
5 achieving integration and coordination is
6 information continuity.

7 Now information continuity is the
8 ability to provide a continuous flow of data
9 and synthesized information across all of
10 the people and units that are involved in a
11 patient's care and it doesn't happen often.

12 The third thing we know is that our
13 current lack of integration and organization
14 of care reflects at least two things. The
15 next two exhibits you will find which come
16 from surveys that we do across countries,
17 and these come from a survey of primary care
18 physicians that was done almost exactly a
19 year ago, show that there has been very slow
20 adoption of health information technology in
21 the United States. We and Canada are
22 towards the bottom of the pack there among
23 health information technology for primary
24 care physicians and although Massachusetts

1 does somewhat better than the rest of the
2 country, and larger groups and there are
3 several here tend to do better than smaller
4 practices, we are still not approaching the
5 kind of levels that you see out on the
6 left-hand side of the slot.

7 And also some people or physicians
8 in some other countries have much greater
9 functionality than is used in this country
10 but there we are not on the bottom of the
11 pack -- we are about 4 in on the right-hand
12 side.

13 This is beginning, by the way, to
14 be addressed at the national level, in part
15 thanks to the appointment of a strong
16 National Coordinator for Health Information
17 Technology, Doctor David Blumenthal who is
18 from here and about 30 billion dollars of
19 funds specifically for health information
20 technology that are in the American Recovery
21 and Reinvestment Act of 2009 also known as
22 the Stimulus Bill.

23 Another key factor that fosters
24 lack of organization and lack of integration

1 of care is the current payment incentive
2 structure for health care. It is
3 predominantly fee for service which
4 encourages higher volume of services and
5 fragmentation.

6 And current payment incentives
7 which also include DRGs don't
8 foster care that meets the highest quality
9 and safety standards. There is no financial
10 incentives for hospitals to reduce emergency
11 room visits, hospitalizations, complications
12 such as central line associated bloodstream
13 infections or re-hospitalizations.

14 Nonetheless, some hospitals aren't
15 participating in efforts in each of these
16 areas.

17 Indeed a group of hospitals in
18 Massachusetts is participating in an effort
19 to reduce re-hospitalization that we are
20 funding and that the Institute for
21 Healthcare Improvement is the grantee for,
22 but many hospital C.E.O.'s are able to sleep
23 comfortable at night without addressing
24 these issues squarely and many feel there is

1 no business case and that they can't afford
2 to address them. It is not necessarily the
3 truth that it has been shown in some
4 settings but it does occur as a feeling.

5 The next exhibit shows the
6 relationship between the two major types of
7 payment reforms that are being talked about
8 today and the organization of the delivery
9 system.

10 Now the two major types of reforms,
11 bundling and pay for performance have very
12 different objectives.

13 The principal objective of bundling
14 is to stimulate more efficient use of
15 services; whereas the principal objective of
16 pay for performance is to ensure better
17 quality of care and achieve better outcomes.

18 Now there can be some mix of these
19 two obviously but I am talking about the
20 principal objectives and it suggests, by the
21 way, that a payment system that wants to
22 achieve both would probably have some blend
23 of these mechanisms.

24 There is also a range in complexity

1 of each so bundling ranging in complexity
2 from the simple use of DRGs by Medicare
3 which aggregates the hospital services
4 provided in the single admission to full
5 global payment capitation which aggregates a
6 payment for a single patient over a period
7 of time such a year.

8 Pay for performance rates on
9 payments based on simple process measures to
10 more sophisticated measures of coordination
11 and risk adjusted outcomes of care.

12 And there are also it turns out is
13 a range in delivery system organization. If
14 you think about it, it ranges from very
15 small practices, solo, two'zies, three'zies,
16 single hospitals, out into through various
17 kinds of physician hospital organizations
18 and physician organizations, multi-specialty
19 group practices and then fully integrated
20 physician hospital delivery systems.

21 It is much more feasible to achieve
22 higher performance, i.e. more effective and
23 more efficient care in the more organized
24 forms of delivery system.

1 Although, as I mentioned earlier,
2 the organization itself is not a sufficient
3 condition to ensure that.

4 There are many ways that hospitals
5 can or I should not say hospitals, there are
6 many ways that organizations can achieve
7 better health outcomes for their patients at
8 lower costs and these are detailed actually
9 in the report by someone who works with us
10 Douglas McCarthy and there is a reference to
11 it in the printed testimony and it its on
12 our website.

13 The challenge is to drive health
14 care delivery from its current mostly
15 fragmented unwired state into the
16 organizational structures that are at least
17 capable of achieving the desired health and
18 cost outcomes.

19 You are undoubtedly familiar with
20 Mass Blue Cross/Blue Shield's alternative
21 quality contract which is one model that one
22 payer has adopted for encouraging
23 organization and performance.

24 There are others. And others being

1 employed by Blue Cross/Blue Shield in
2 Michigan and it is interesting because its
3 physician group incentive program is a pay
4 for performance program that rewards both
5 quality and cost performance. It involves
6 about 6,500 physicians in Michigan. The
7 payments are made only to groups of
8 physicians such as a physician organizations
9 and electronic data collection and sharing
10 is a requirement of participation.

11 In an effort to create program
12 ownership, it is physicians who structure
13 the initiatives for the insurers.

14 One concerning about stimulating
15 the development of large health care
16 delivery organizations is reflected in the
17 recent preliminary report of Attorney
18 General Coakley on health care cost trends
19 and cost drivers in the state and a similar
20 report from the Office of the Health
21 Insurance Commissioner of Rhode Island.

22 And both of these reports provide
23 evidence that market leverage is a dominant
24 driver of current payment and that is an

1 issue that needs to be dealt with and will
2 require strong and talented leadership at
3 all of the levels it is occurring, national
4 state and local. It is going to involve
5 addressing head on very complicated issues
6 of health care design and financing.

7 Speaking personally, again, I
8 believe that at a minimum we are going to
9 have to achieve price and performance
10 transparency and possibly we will need all
11 payer prices or all payer rate setting.

12 Only two states, Maryland and
13 West Virginia, currently have all payer
14 hospital rate setting.

15 In the early 1990's, it was thought
16 that managed care would be more effective at
17 controlling hospital costs and health care
18 spending than regulation. Yet during the
19 period of 1975 to 1991 when Massachusetts
20 had its program, the increase in hospital
21 costs here averaged 20 percent below the
22 U.S. as a whole and since discontinuing the
23 program, Massachusetts increases in hospital
24 costs have been slightly above the national

1 average.

2 It is worth remembering that there
3 are many ways to bend the cost curve. And
4 we have but out a couple of reports. One
5 was the original bending of the curve report
6 back in December of 2007, and another was
7 one path to a high performance U.S. health
8 system in February of 2009 and both include
9 modeling a variety of options for changing
10 cost at a national level.

11 Now, what the point that I want to
12 make with this slide is that the ways of
13 bending the cost curve relate not just to
14 payment reform and regulation but to diverse
15 efforts such as generating better evidence
16 and deploying it to achieve evidence-based
17 medicine and informed decisions by patients
18 and increased efforts to control obesity,
19 tobacco and substance use, things that lead
20 people to use health care services to a
21 greater degree and incur costs.

22 To change the existing cost trends
23 is going to require full court press and
24 this simply doesn't occur without strong and

1 competent leadership at the national and
2 state levels. Government's levers should be
3 exercised in the context of goals for
4 performance of the health system and we
5 currently have no national goals and I am
6 unaware of explicit state goals.

7 In setting goals, it is highly
8 unlikely that the state or the nation can
9 fully satisfy all disparate interests within
10 it and for the sake of discussion I am going
11 to assume that one goal is going to be the
12 bend the cost curve and one of the
13 strategies will be to develop more robust
14 primary care, which has been a sine qua non
15 in almost every country that has better
16 outcomes and lower costs than the
17 United States does.

18 Yet, how will you do this in
19 Massachusetts? The state has an excellent
20 large highly specialized and sub specialized
21 physician work force even though in primary
22 care oriented health systems specialists and
23 subspecialist are still essential to
24 provision of excellent care, one needs

1 relatively fewer of them than we have today
2 in relation to the number of primary care
3 physicians or primarily care practitioners.
4 And another example of the strategy to bend
5 the cost curve and provide higher quality of
6 care would be to develop a group of locally
7 organized after hours services across the
8 state to reduce the use of emergency rooms
9 and decrease hospital admissions.

10 The Netherlands and Denmark both
11 have required and developed such programs.
12 In both countries they are physician
13 organized and have achieved excellent
14 results.

15 Yet another state strategy might be
16 to encourage substitution and competent but
17 less expensive labor, for more expensive
18 labor. This is likely to require a change
19 in various state scope of practice laws and
20 regulations. It is predictable that
21 proposing such changes is going to pit
22 various groups of professionals and workers
23 against each other and the state.
24 Physicians and nurses, subgroups of

1 physicians and nurses -- subgroups of
2 physicians such as ophthalmologists versus
3 optometrists, nurses and nursing assistants.

4 So those are issues that will need
5 to be dealt with if one chooses that
6 approach in to trying to change the cost
7 curve.

8 So in order to set goals and
9 develop and implement strategies to achieve
10 them it is going to be critically important
11 for government to convene the key
12 stakeholders whose participation is
13 essential to achieving the goals, recognize
14 that the various stakeholders do have
15 conflicting interests and seek to come up
16 with a fairest solutions consistent with the
17 goals.

18 Finally, and certainly not least,
19 it is extremely important to engage the
20 public or patients. They must be convinced
21 that whatever is done will yield as good or
22 better care and more affordable care than
23 they otherwise would have.

24 The national reform debate has

1 shown that this is an uphill battle. The
2 public may be beginning to realize that the
3 U.S. health system could perform better but
4 most individuals who do have insurance
5 coverage and access to health care, believe
6 that there own care is at least satisfactory
7 if not excellent and they fear change.

8 The major issue for individuals has
9 been costs of care, bought contributions for
10 coverage and out-of-pocket costs yet efforts
11 to reduce health care costs are greeted
12 suspiciously by the public and individuals
13 as efforts to stint on needed health care
14 services.

15 So the public must understand just
16 what is being done and why and ideally the
17 public should be integrally involved in the
18 process as should all of the other key
19 stakeholders.

20 The central principle of patient
21 centered care "nothing about me without me"
22 should also be a central principle of
23 efforts to reform the health system and
24 improve its performance.

1 Thank you.

2 (Applause from the Audience.)

3 PROFESSOR STANLEY WALLACK: As
4 Commissioner Morales said we are going to
5 take -- we really want questions from you
6 who you sitting here with us. I think they
7 were very helpful on Tuesday in sort of
8 getting some issues addressed but what I
9 plan to do -- whoever has the clicker -- we
10 will maybe go back to figure, Exhibit 7.
11 What I want to do is actually use that.

12 I want to try to structure the
13 discussion with Steve is around sort of what
14 this -- what I sort of consider the macro
15 picture, kind of the major dimensions and
16 then I am going to move down to those of us
17 who worry about some of these microprocesses
18 in organization and so I am going to talk
19 about this framework and then I want to talk
20 about how do we really get organizations to
21 be paid patient centered and then I want to
22 move on to, I think, the Commonwealth's work
23 that Steve got into -- what kind of policies
24 do we need to think of with anti-trust and

1 with regards to other actions that the state
2 needs to be involved.

3 This isn't going to happen simply
4 by looking at the private sector all by
5 itself.

6 So let me start off with the first
7 one and Steve mentioned when he first
8 introduced himself, he said he knows
9 Massachusetts. I think he knows
10 Massachusetts very well.

11 He spent at least 20 years here in
12 the '80s and '90s, working with the Harvard
13 system, Harvard Health Plan and he was in
14 both in Massachusetts and Rhode Island and
15 so what I would like to start off the
16 question to Steve with given your knowledge
17 and given your experience with high
18 performance health systems is to let's start
19 off around the team of organizations.

20 Give us the sense given that you
21 know Massachusetts, how can we start to move
22 from left to right -- what are the kinds of
23 things that you think are most important
24 that you recommend?

1 You can sit down.

2 DOCTOR STEPHEN SCHOENBAUM: Well,
3 this is at a critical question and I don't
4 have an easy answer to it.

5 Our Commission has been struggling
6 with it, I would say now for about two years
7 and clearly it has something to do with how
8 do you offer incentives could be mostly
9 positive, possibly some negative ones that
10 make the status quo more uncomfortable but
11 probably mostly positive ones that get small
12 practices to aggregate and not aggregate
13 solely for the purpose of negotiating higher
14 prices with payers which happens if they are
15 single specialty groups but rather in the
16 multi-specialty groups.

17 How do you get them to then work on
18 some combination of quality and cost
19 management?

20 Well, the closest that anyone is
21 coming to that is this idea of developing
22 accountable care organizations and that is
23 presumably a group of providers who take
24 responsibility for quality and cost

1 performance, and the models that I think
2 still need to be worked out with and need to
3 be worked out so that all of the parties
4 feel like they are getting a reasonable
5 deal.

6 And let me see if I can parse some
7 of what I just said. It is likely and I
8 will go back to some themes that I have
9 already raised. It is likely that if one
10 has an accountable care organization that is
11 accountable for a population, it is going to
12 need to be more primary care oriented.

13 I think the data is compelling.
14 They have been put together by Barbara
15 Starfield who is a professor at the Johns
16 Hopkins Bloomberg School of Public Health
17 and has worked in this area for years and
18 they show that countries and parts of the
19 United States that have more primary care
20 services have better outcomes, lower costs
21 and more equity of care.

22 There are a number of features that
23 are related to that and there is some debate
24 about what those features are and let's say

1 which of those features has the dominant
2 importance.

3 I think Barbara Starfield herself
4 would say it is the comprehensiveness of the
5 primary care practice. It is their ability
6 to handle within the practice most of the
7 problems that they see and not necessarily
8 need to send people to a consultant for
9 every single individual problem that they
10 have. So that doesn't mean just having
11 people who call themselves primary care
12 physicians or primary care nurse
13 practitioners but people who have skills in
14 the whole variety of office forms,
15 ambulatory forms of let's say dermatology,
16 ophthalmology, ENT, mental and behavioral
17 health. A lot of mental and behavioral
18 health issues come up in a primary care
19 practice and orthopedics, OB/GYN.

20 I mean there are all sorts of
21 issues here that ideally would be handled in
22 that practice.

23 As people have started thinking
24 about how do you get that, they start

1 talking about this thing that has lately
2 been called medical homes. There are also
3 people who don't like that term. But
4 whatever you want to call it, it is really
5 comprehensive patient-centered team-based
6 primary care and to not somehow imbed that
7 kind of structure into an accountable care
8 organization, I think will doom it to
9 failure in meeting certainly the cost goals
10 and probably the quality as well, because
11 Starfield has always showed both of those as
12 a result of a more dominantly primary care
13 oriented systems.

14 PROFESSOR STANLEY WALLACK: Okay,
15 let me -- there are a number of questions
16 from the audience already -- let me follow
17 up on one.

18 The way you started with was the
19 idea of small group practices maybe joining
20 with others and starting to grow to become
21 this more comprehensive service and you
22 mentioned this model going on in Michigan,
23 the physician group incentive program.

24 We had worked over the years with

1 Henry Ford in our physician group practice
2 demonstration as a leadership organization,
3 but is that statement -- would you just give
4 me a few more comments about that model --
5 how comprehensive it is -- how physicians
6 are actually -- how they desire to work --
7 are they looking to move into that program?
8 Are they happy with that program?

9 DOCTOR STEPHEN SCHOENBAUM: The
10 honest answer is we don't know yet and this
11 limited amount of data that is available
12 through things like the Michigan Blue
13 Cross/Blue Shield website, however, we -- I
14 believe the Commonwealth Fund's Board has
15 yet to meet -- it meets in April but being
16 proposed to it is an evaluation of that
17 program and until we have that evaluation,
18 it is really very hard to say.

19 If you ask me, it sounds like it is
20 a very effective pay for performance
21 program. It is interesting with the feature
22 that I mentioned which is that it doesn't
23 just address quality, it also addresses
24 costs.

1 And I would assume that it is going
2 to turn out to be working better than, let's
3 say, the Integrated Healthcare Association
4 in California which is trying to do this now
5 for several years and has been evaluated by
6 Meredith Rosenthal here at the Harvard
7 School of Public Health and where, in fact,
8 there seems to be relatively minimal effects
9 in that instance of the pay for performance.

10 PROFESSOR STANLEY WALLACK: Here
11 is a question from the group, how might ACOs
12 help make sure the state health care system
13 doesn't add too many duplicate high cost,
14 high intensity settings?

15 How do ACOs get us to the right
16 number of centers of excellence assuming we
17 have this world of ACOs in the state?

18 DOCTOR STEPHEN SCHOENBAUM: Let
19 me start from the other side which is
20 suppose you are running a center of
21 excellence and it is a little presumptuous
22 of me to put myself in the place of some of
23 the people that will be on the next panel,
24 but, in fact, I think they have a choice if

1 -- let's assume there is a strong
2 accountable health care organization that is
3 developed, it is going to need highly
4 specialized services. It is going to want
5 those to be provided with ways that achieve
6 the best outcomes at the lowest obtainable
7 costs.

8 And so one role for places that are
9 highly specialized in particular areas which
10 is how I am interpreting the centers of
11 excellence here is to be offering those
12 services to one or more accountable care
13 organizations.

14 A second potential role is for them
15 to become accountable care organizations and
16 be the organizer of the larger delivery
17 system.

18 Either one of those is a stretch,
19 but I think both are do'able and what I
20 don't know is whether the proposals for what
21 are the benefits of being an accountable
22 care organization will be sufficient to be
23 enticing to these institutions that are
24 centers of excellence that are probably the

1 most organized parts of the current health
2 care system to then go in one or another of
3 those directions.

4 PROFESSOR STANLEY WALLACK: It is
5 certainly true of the state. Lois?

6 ASSISTANT ATTORNEY GENERAL

7 LOIS JOHNSON: Just to follow up as you have
8 noted there is a very real concern that the
9 more we sort of move to the right and
10 encourage integration and merging and
11 creation of larger systems, not one'zies,
12 two'zies or joining group practices -- it
13 raises a concern of stimulating the kind of
14 market leverage that the Attorney General's
15 report documented -- how do we counteract
16 that?

17 What kind of measures of efficiency
18 or price can we use to benchmark these
19 groups.

20 DOCTOR STEPHEN SCHOENBAUM: Well,
21 I try to elude to a couple of those in the
22 testimony.

23 I mean one possibility is that one
24 does rate setting particularly when somebody

1 is exhibiting market power because that is
2 an approach to dealing with it.

3 There is a paper, I just got an
4 e-mail earlier this morning before the
5 session that is in Health Care published
6 today showing that Medicare is not
7 profitable for hospitals that have a lot of
8 market leverage because they have high cost
9 structures whereas it is profitable for the
10 ones that don't have a lot of market
11 leverage because they have had to be very
12 efficient in their use of resources and they
13 can actually not only survive but it sounds
14 like and I haven't read the paper yet to
15 some extent profit from the Medicare
16 reimbursement rates.

17 So there may be a message there as
18 to how do you then, or at least it gives you
19 a direction as to how do I modulate the
20 market power. And it is a role for having
21 leadership.

22 I didn't think that the private pay
23 years on their own can do that.

24 PROFESSOR STANLEY WALLACK: Okay.

1 DOCTOR STEPHEN SCHOENBAUM: Well,
2 another approach, by the way, I mentioned
3 that I didn't go into was price setting and
4 transparency, and the only problem with that
5 is that if people won't leave, let's say,
6 the local area to even go next door then the
7 fact that the prices are the same for all
8 payers and everyone knows them but they are
9 20 percent higher 10 miles away still won't
10 make a difference in the raw cost.

11 ASSISTANT ATTORNEY GENERAL

12 LOIS JOHNSON: Just to follow up, in terms
13 of -- I think one of the questions I was
14 trying to get at are what are the
15 measurements for measuring efficiency you
16 mentioned that you sort of in your studies
17 you looked at the use of efficiency or how
18 states are with efficient use of resources
19 and do you have any thoughts on metrics of
20 efficiency of individual organizations like,
21 for example, the use of total medical
22 expenses or what other measures of
23 efficiency can be used to ensure that
24 practices are using resources in the best

1 fashion.

2 DOCTOR STEPHEN SCHOENBAUM: It is
3 a difficult area as I am sure you know and
4 what we did and this is only a first step
5 along the line.

6 We gave a grant now about two years
7 ago -- the product I think has just been
8 published by the National Quality Forum
9 which is a frame work for the development of
10 efficiency measures which is yet a step
11 before getting to your question which is do
12 I have out of the prow of Zeus or something,
13 a set of really great efficiency measures.
14 I think the other challenge is are we going
15 to use the term efficiency the way it might
16 be used or are we going to use it the way it
17 is used in common parlance?

18 Are we going to refer to some
19 relationship of quality and cost or are we
20 simply going to refer to cost?

21 And I think that we ought to always
22 have some idea of what the balance of those
23 two is, and whether we deal with them
24 together in one measure which is how I would

1 ideally like to see efficiency measures and
2 I think that those are very difficult to
3 create or whether one looks at two measures
4 together, i.e., how does one do in quality
5 and how does one do in cost and then look at
6 the relationship of those two which is a lot
7 easier.

8 Is an open issue but it is probably
9 going to go the latter way.

10 PROFESSOR STANLEY WALLACK: You
11 know, I think your point is really good.

12 I mean I think you have got to put
13 those two things together and I think you
14 can look at quality improvements and then as
15 you measure lowest -- you could look at
16 savings on a total person basis.

17 So I think the point is putting
18 them both together in some way but building
19 them up is this idea, I think, we are all
20 stressing about quality and needing a direct
21 metrics about that.

22 There are a lot of questions, guys.
23 Let me give you another one from the
24 audience.

1 Would you please comment -- this
2 follows some of the discussion you just had,
3 Steve, more of the lessons learned on price
4 and care setting in Maryland, West Virginia
5 and elsewhere, what opportunities and risks
6 would it present for Massachusetts.

7 DOCTOR STEPHEN SCHOENBAUM: Well,
8 as I mentioned, Massachusetts has been
9 there. It discontinued its process. I am
10 not an expert in this particular area. We
11 did have a paper. It has been published in
12 the last six months or so maybe a little
13 longer, I think it was in August, a paper by
14 Graham Atkinson who is an expert and worked
15 with the Maryland Rate Setting Commission
16 for a number of years and is now a
17 consultant in Washington D.C. who wrote a
18 paper showing what the trends have been
19 during the times that states have had or not
20 had all payer rate setting processes of one
21 sort of another in place and he describes
22 each of those, each of seven states of which
23 only Maryland and West Virginia persisted.

24 So I would refer people there and

1 if there is a residual question, I would be
2 glad to connect whoever has it with somebody
3 like Doctor Atkinson.

4 PROFESSOR STANLEY WALLACK: You
5 are right. He started with the Maryland
6 system when it first got started.

7 A plug for economists though -- the
8 system was developed by an economist so each
9 institution could actually set sits own
10 price much like what you talked about based
11 on its own cost. We wanted to do something
12 to sort of get to the lower cost point but
13 we also wanted to encourage managed care.

14 When you look at the Maryland
15 system, you both have a tremendous growth in
16 managed care very high rate as well as price
17 regulation.

18 And, you know, it is really, I
19 don't think we should think about
20 competition and regulations being two
21 things -- we have to think of either
22 regulate the system or competition and I
23 think they can be actually brought together
24 and I think Maryland is great example of, in

1 fact, where it was brought together and I
2 have a paper on that that I can share with
3 you.

4 So let me move onto one other thing
5 here. What I found really intriguing, and I
6 think by the way, you should know that this
7 initial, this initial picture was developed
8 by Tom Lee and Jim Mongan at Mass. General
9 and then the Commonwealth Fund took the
10 picture and actually made a very important
11 modification in separating the payments,
12 the bundling of payment from the pay for
13 performance. I think that that is a really,
14 really good idea.

15 What I was intrigued by and again
16 because we are all talking about getting
17 away from fee for service, and is this idea
18 of you moving up, up towards the outcomes
19 measures. I think you are right. We are
20 now in the process measures and we have to
21 deal with the service basis because we move
22 to outcome measures.

23 We can start to maybe, you know,
24 make a larger percentage of the total

1 payment based on value -- based on outcomes.
2 Would you give is a sense of what you think
3 about magnitudes?

4 I mean I think the current pay for
5 performance has small dollars involved.

6 What have you been thinking about
7 in terms of the magnitude and how much we
8 can move to an outcome based payment system
9 as we go to more integrated systems. I am
10 reading your diagram and I am excited.

11 DOCTOR STEPHEN SCHOENBAUM: Well,
12 you know, outcomes, there are intermediate
13 outcomes and there are sort of real outcome
14 end points. We know that they are all
15 variable.

16 So one intermediate outcome that is
17 fairly close to down to the processes is
18 re-hospitalization which I tend to think of
19 as a real offense to a patient.

20 If you have ever been in a hospital
21 and discharged, you expect that you have
22 been taken care of and that that is the end
23 of the process.

24 In most instances -- there are any

1 number of conditions you might have where
2 you don't expect that you are going to
3 bounce back, but, in fact, if you have a
4 condition that you thought was taken care of
5 but to now have an unexpected readmission
6 which ought to be preventable is I think an
7 extremely important event and it is a
8 relatively measurable outcome although
9 people are still working on what the
10 measures are.

11 But we also know that mortality is
12 a measurable outcome and that some hospitals
13 are changing their rates of that -- the
14 institute of health care improvement has
15 been looking at this offer a couple of years
16 now and there are certain -- there are
17 certainly hospitals that have in their terms
18 moved their dial, so that is an outcome as
19 well, that one can talk about and it is one
20 that is rather important.

21 PROFESSOR STANLEY WALLACK:

22 Absolutely, those are very good measures,
23 but I was actually intrigued by the
24 percentage of the payment that it could be

1 based on outcomes or value rather than just
2 paying on the basis of volume.

3 Is that -- throw it out -- if we
4 move from 1 to 2 percent on pay for
5 performance -- we do it on process measures
6 to 25 percent when we move to outcome
7 measures when we have integrated systems?

8 DOCTOR STEPHEN SCHOENBAUM: First
9 of all, I am not sure that one or two
10 percent is working. I think that that is
11 the problem with integrated health care
12 issues in California.

13 So, yes, I think you are probably
14 talking about double digit percentages
15 possibly both for processing and for
16 outcome.

17 And, again, I am not sure why there
18 should be any particular problem with that.
19 It is just that if you are trying to balance
20 let's say these different modes of payment
21 and some kind of blend, then you don't want
22 one to be 98 percent and the other 2 --
23 whichever way it goes.

24 PROFESSOR STANLEY WALLACK: Let

1 me ask at least one of my questions and I
2 maybe I will look through the cards at the
3 same time. I think we are running out of
4 time. I got your message here.

5 I think you start off at the front
6 of your talk with talking about patient
7 centered care and how important that is as
8 we move forward.

9 And we had a wonderful discussion I
10 thought on our first day Tuesday with a
11 consumer panel talking about wanting to be
12 involved, just the things you said.

13 You know, they wanted to be a
14 stakeholder, they had really good ideas,
15 they wanted to contribute to the debate.
16 Yet I think when you look at a model like
17 this you don't see the patient and yet when
18 we think of high performing organizations in
19 the non-health area and you think of those,
20 the best practice ones are always ones that
21 know their client. They are the ones that
22 know the market, they are the ones that know
23 the client. The apples of the world -- and
24 they deliver to them. It is very demand

1 focus. They are looking at that whereas a
2 lot of what we are seeing coming out is very
3 much supply focused. I mean organization,
4 doctor driven.

5 Can you give us an example of a
6 really good system -- we are not going to
7 ask you to identify it -- but a high
8 performing system where the patient is
9 really at the core of it and what does it
10 require to get us there?

11 DOCTOR STEPHEN SCHOENBAUM: First
12 I think to go to what it requires, it
13 requires the same kind of thing it takes to
14 get us towards perfection and safety and to
15 very high use of effective procedures and so
16 on.

17 It requires commitment either at
18 the very top of the organization by the CEO
19 or by someone with enough power to make
20 change happen within that organization. So,
21 I don't think it can happen solely from the
22 grass roots of an organization. It
23 ultimately has to involve the grass roots
24 and involve everyone in it but it is really

1 part of a whole culture. There are
2 organizations that do it. I think if you
3 are the one that comes to mind that is a
4 couple of miles from here is now the Dana
5 Farber where patients are involved, as I
6 understand it, on virtually all of the
7 important committees of the organization.

8 And when they were searching I am
9 told I think I remember this story
10 correctly, that when they were searching for
11 their chief operating officer after Jim
12 Conway went to the Institute for Health Care
13 Improvement one of the candidates said why
14 there was a patient or a family member
15 involved in interviewing me and that was a
16 disqualifying question as I heard the story
17 which was that, you know, the kind of person
18 that was required by the institution for
19 that role was going to have to be somebody
20 who already was bought into the idea that it
21 was really important for patients to be
22 involved in all of the key processes
23 including the selection of the next chief
24 operating officer.

1 PROFESSOR STANLEY WALLACK: I
2 have the last question and I am going to add
3 my thought onto the end of this one so just
4 to prepare you for that it is going to be a
5 two part question for my last question.

6 A question from someone here -- is
7 there any country that the Commonwealth Fund
8 has studied that performs better than the
9 U.S. that does not use some type of global
10 budget or cap on total spending as a means
11 to control? I want you to answer that
12 question and given your experience and work
13 in Great Britain -- why don't you use Great
14 Britain as an example -- because there they
15 are really trying -- not only the global
16 budget but they are trying to work on
17 quality and they are using the concepts of
18 lean manufacturing and they are really
19 emphasizing the patient.

20 So maybe you could talk about the
21 global budget on the one hand with any other
22 countries but also talking about even within
23 global budget how they really orient
24 themselves to the patient and England is a

1 good example of what is going on in
2 Great Britain.

3 DOCTOR STEPHEN SCHOENBAUM: I am
4 having difficulty with the first part which
5 is that I am not coming up with a country
6 that doesn't have some way of at setting the
7 least spending targets.

8 PROFESSOR STANLEY WALLACK: I
9 will give you that.

10 DOCTOR STEPHEN SCHOENBAUM: That
11 is not necessarily the same as having a
12 single payer.

13 PROFESSOR STANLEY WALLACK:
14 Right.

15 DOCTOR STEPHEN SCHOENBAUM: And
16 exactly one budget. So you do have
17 countries like the Netherlands where they
18 have now an entirely private payer system
19 but it is a very regulated group of papers
20 and that undoubtedly effects --

21 PROFESSOR STANLEY WALLACK: There
22 is that example again when they created
23 competition within its overall budget.

24 DOCTOR STEPHEN SCHOENBAUM:

1 Correct. So there is that and I am missing
2 the first part.

3 PROFESSOR STANLEY WALLACK: No,
4 that is a good answer.

5 I was going to ask you to talk. I
6 think what England is doing now is probably
7 a most interesting thing that is going on
8 with regards to lean manufacturing and lean
9 production where to do that you really
10 emphasize the patient again.

11 I am very much interested in how we
12 move to a demand side approach on this and
13 to the patient.

14 I want to know if you can comment
15 on your view now what is going on in Great
16 Britain. That is the last question.

17 DOCTOR STEPHEN SCHOENBAUM: Yes,
18 somehow I am reminded that whenever you
19 mention that one of my other roles -- I am
20 on the Board of the Picker Institute and
21 while we are not responsible for something
22 called Picker Institute Europe which is
23 based in Oxford, England, there is one and
24 that organization is one that is interested

1 in patient experience both in terms of
2 providing outcomes information and there are
3 certain things that you can only learn from
4 patients, and also for optimizing patients'
5 experiences.

6 The National Health Service a
7 couple of years ago probably because it is
8 patients vote in England and there is a
9 National Health Service, seemed to have an
10 epiphany, and felt that it was really
11 important to emphasize patient experience
12 and patient centered care in all aspects of
13 the care that was being delivered.

14 And I think that there is evidence
15 and I just got a bulletin from Picker
16 Institute Europe yesterday that patient
17 experiences in a variety of settings -- this
18 one was about an ambulatory care -- are
19 improving over time. That the trend is to
20 improving but again it is a central
21 concentration and it is as if they had set a
22 goal and if I have a valedictory remark that
23 I can make it is to go back to the idea of
24 setting goals that I mentioned in the

1 testimony that there is no reason why that
2 can't be done at a governmental level, but
3 it would be an inclusive process and I would
4 also go a step further which I didn't
5 mention in the testimony and I think that
6 there can be certain standards that are set
7 for performance and that there are standards
8 that would enhance patient centered care,
9 coordination of care, potentially decrease
10 cost or improve quality and I will give you
11 an example of those which is that I would
12 think that every patient who goes to an
13 emergency room ought to be discharged with a
14 legible set of discharge recommendations
15 that also sit on the desk of their primary
16 physician assuming that they have one. 90
17 something percent of Americans do say that
18 they have a doctor, that there be something
19 that sit there within X number of hours, you
20 can set X.

21 Today physicians don't necessarily
22 know when their patients come to the
23 emergency room. There are hospitals, and I
24 see the CEO of one of them in the room why,

1 in fact, computerized summaries are given to
2 people and they are legible but that doesn't
3 happen everywhere in the United States. It
4 is not the standard practice and I suspect
5 it is not in Massachusetts as well.

6 PROFESSOR STANLEY WALLACK:

7 Listen, Steve, this was great. I appreciate
8 you taking the time.

9 Thanks you for all of the work.

10 (Applause from the Audience.)

11 COMMISSIONER MORALES:

12 Thank you, Professor Wallack and thank you
13 Steven Schoenbaum.

14 We are going to take a two-minute
15 break while we organize our next panel.

16
17 (Short Recess.)

18 COMMISSION MORALES: If we could
19 get started, again, thank you, Attorney
20 General Martha Coakley for being with us
21 today, Representative Mary Grant, Vice
22 Chairwoman of Health Care and Financing, the
23 Representative.

24 Before I get started I want to

1 introduce Michael Bailit who will moderate
2 our panel, but first I would ask the
3 Stenographer if you don't mind to swear in
4 the panel.

5 THE STENOGRAPHER: Would you all
6 stand and raise your right hand.

7 Do you solemnly swear that the
8 testimony you about to give in the matter
9 now at hearing will be the truth, the whole
10 truth and nothing but the truth, so help you
11 God.

12 Please identify yourself by raising
13 your hand if your testimony today is limited
14 for any reason, there are any restrictions
15 placed on the capacity in which you testify
16 here today, you have any conflicts of
17 interest that require disclosure.

18 (James Roosevelt, Jr. raised his hand.)

19 THE COURT REPORTER: The Division
20 requests that you submit a written statement
21 for the record disclosing your specific
22 restrictions or conflicts by 3/26/10.

23 MR. JAMES ROOSEVELT, JR.: The
24 statement will simply identify that I am

1 speaking for myself and for Tufts Health and
2 although I am Board Chair of the
3 Massachusetts Association of Health Plans, I
4 am not speaking in any authorized capacity
5 for them today.

6 MR. MICHAEL H. BAILIT: Good
7 morning everyone.

8 This panel has been created to
9 discuss the health care delivery system in
10 the context of costs and cost trends.

11 The members of the panel are Phil
12 Gaziano, the Medical Director of Hampden
13 County Physician Associates; Jim Roosevelt
14 who just introduced his affiliation and Paul
15 Levy, President of the Beth Israel Deaconess
16 Medical Center; Don Goldmann, Senior Vice
17 President for the Institute for Healthcare
18 Improvement; and Jack Dutzar, President and
19 Chief Executive Officer of the Fallon
20 Clinic; Barbra Rabson, Executive Director of
21 the Massachusetts Health Quality Partners;
22 Barbara Spivak, the President of the
23 Mount Auburn Cambridge IPA.

24 I am going to ask the panel at the

1 outset that you please speak clearly. I
2 will direct questions individually to you.
3 While you may be tempted at times to want to
4 jump and respond to one another I want you
5 to ask you to please respond from doing so
6 as there are question a few questions I
7 would like to get through with you today.
8 The focus of this panel is, of course, going
9 to be on the delivery system but
10 specifically what are some of the problems
11 that we experience in the delivery system
12 that contribute to health care costs, and so
13 I want to put a little less emphasis on
14 solutions and a little bit more on problem
15 identification today.

16 I would like to start in the
17 context of the charts to my right and the
18 reports that have been issued by the
19 Attorney General's Office and the Division
20 of Health Care Finance and Policy with a few
21 questions specific to market dynamics and
22 that being market dynamics primarily and not
23 exclusively between payers and providers in
24 Massachusetts and how they contributed to

1 growth and health care spending.

2 So these recent reports are
3 articles in The Boston Globe over the last
4 year and-a-half and other publications have
5 talked to market dynamics in Massachusetts
6 and how they have contributed to cost
7 growth.

8 The Urban Institute did a brief on
9 our cost problems about a year ago, a little
10 over a year ago. In it they wrote there
11 seems to be little evidence of active
12 competition on costs and prices between
13 dominant players and with other hospitals in
14 there local markets.

15 The cost growth in the state is
16 driven by market power of the leading
17 systems.

18 Now in the context of these graphs
19 we might want to dispute whether it is only
20 leading systems and perhaps we might also
21 extend the concept not just to hospitals but
22 to other providers of services, but I would
23 like to ask first, Jim, whether the lack of
24 price and quality competition among

1 providers is a primary driver of health care
2 cost growth in Massachusetts.

3 MR. JAMES ROOSEVELT, JR.: Are we
4 permitted in this section to make -- to give
5 our testimony?

6 MR. MICHAEL BAILIT: Your
7 testimony -- I am sorry -- I forgot and I
8 was so eager to ask my questions. So
9 remember that question.

10 And let me first allow you to give
11 your testimony, so please give your
12 testimony in three to five minutes and we
13 will come back with that question. I will
14 start with Jack here and we will just go
15 down the table.

16 DOCTOR JACK DUTZAR: Good
17 morning, everybody. It is a delight to be
18 here representing our organization and be
19 here with you on this enormously important
20 subject.

21 Thirty years ago when I first
22 started working in health care management, I
23 learned by first joke which went something
24 like cost, quality and access -- pick any

1 two.

2 Over the years, I have been more
3 than convinced that nothing as complex as
4 the issues that we have in health care
5 delivery can be reduced to anything quite
6 that simple.

7 What I do believe, however, is that
8 there is some truth in it in the sense that
9 we spend our time managing those three
10 elements and they are always inextricably
11 linked to each other.

12 We are here to testify today
13 regarding the costs of health care, and what
14 drives that cost and what we can do to bring
15 it under control.

16 Speaking for our organization, the
17 Fallon Clinic we have a longstanding
18 commitment to focus on that topic in service
19 to our patients and to the communities which
20 we serve. Our mission state includes the
21 phrase "appropriate use of health care
22 resources".

23 The Fallon Clinic is a
24 free-standing multi-specialty group practice

1 of nearly 300 clinicians and just under 200
2 employees in central Massachusetts.

3 Nearly two thirds of our 200,000
4 patients come to us with coverage that is
5 for prepaid care or otherwise -- for us
6 comfortably known as capitation.

7 We are strong components of
8 capitation as a preferred method of
9 reimbursement primarily because it allows us
10 to focus on the clinical needs of our
11 patients and to invest in health care
12 delivery structures that support them
13 especially patients who are most vulnerable.
14 Our incentives are to keep our patients
15 healthy and provide them with all of the
16 health care that they need.

17 We believe both that we are
18 fundamentally more efficient than most of
19 the systems around us and that we have much,
20 much more to do in achieving a higher level
21 of efficiency.

22 The somewhat opaque nature of the
23 relationship between payers and providers
24 however keeps us from knowing and placing

1 ourselves on a continuum of how inefficient
2 we are and to what degree we may be part of
3 the problem.

4 Our current level of efficiency at
5 our current level of reimbursement is not
6 leading to significant margins.

7 My personal message is our
8 Commonwealth considers options for
9 controlling the costs associated with our
10 commitment to universal coverage and our
11 very highly regarded care delivery is to not
12 forget the lessons of the past even the
13 recent past.

14 Fee for service reimbursement
15 provides access but it is a fundamental
16 factor in increasing costs.

17 Managed care in its many forms can
18 control the trends. Between 1993 and 2000
19 it has been estimated that the
20 United States saved over a trillion dollars
21 in treaded health care costs during the
22 expansion of managed care and H.M.O.
23 products.

24 When providers are at risk,

1 however, they rely on incentives that create
2 real improvements in costs and quality.

3 The declining managed care across
4 America after 2000 was due in large part
5 however to the public's reaction to poor
6 access and poor quality.

7 The reason for access and quality
8 issues were at least in part because the
9 strategy placed excessive risk on providers
10 who were unprepared and not structured to
11 manage that risk.

12 I believe that the sweet spot we
13 are all seeking will be hit only with a
14 thoughtful collaboration between payers,
15 providers and patients around how we manage
16 to balance the three parameters of
17 healthcare -- cost, quality and access.

18 Many of the current strategies
19 being pursued will in my opinion lead us,
20 again, to a backlash and not the future we
21 all hoped for.

22 Global payments and prepayment is a
23 recommendation in front of us and we at
24 Fallon Clinic support that recommendation in

1 the strongest possible way.

2 Our success, however, will be found
3 in the details of how we implement those
4 recommendations.

5 Externally applied cost controls
6 and I appreciate the presentation in the
7 prior hour, but nevertheless, if we make
8 that choice, then we should always be aware
9 that it will have a significant potential
10 impact on the other two parameters, quality
11 an access.

12 Finally, continuing and balance of
13 reimbursement for attachable values of
14 representation and/or market dominance will
15 also hurt our efforts to being affordability
16 and stability into our nation-leading
17 efforts of our state to provide quality and
18 access to all residents of the Commonwealth.
19 Thank you.

20 DOCTOR PHIL GAZIANO: Thank you.
21 It is amazing to see everyone coming
22 together to share ideas on a topic that many
23 will find different points of view.

24 I am one of the medical directors

1 of our physician group and our physician
2 group has helped put together networks of
3 about 700 physicians which have been working
4 with global cap contracts for about 12
5 years.

6 After practicing for 20 years
7 myself, and leading providers in different
8 systems, I and some of the 700 or so
9 physicians in our global capitation networks
10 have noticed impediments to delivering
11 quality and efficient care.

12 These drive-up costs and reduce
13 quality and we are ready to move to
14 different systems that will allow us to
15 practice the way we know we can.

16 Most of the impediments are caused
17 by systems setup in the past by well meaning
18 individuals. One example is the Federal
19 regulation requiring fee-for-service
20 Medicare members to stay three days in the
21 hospital even if they don't need it, and
22 expose them to certain risk if they need to
23 go to a nursing home or rehab unit.

24 If the I tent was to protect these

1 individuals, the effect was to increase
2 costs and potentially reduce the quality of
3 the care delivered.

4 And now there is a new
5 Massachusetts regulation enacted in July of
6 2009 that requires a legal guardian be
7 appointed for cognitively impaired patient
8 before admission to a nursing home or rehab
9 unit.

10 I have a patient in the hospital
11 now that came in in the middle of January,
12 and should have gone to a rehab unit the
13 week after admission but due to this
14 regulation and our overburdened courts, my
15 patient is getting the wrong type of care at
16 taxpayer expense and is still in the
17 hospital.

18 Despite these, the largest
19 impairment to efficient quality -- to
20 efficient care and high quality is the way
21 we pay providers. The health care debate
22 should not be about how many payers there
23 are -- single or many or whether they are
24 public or private but what is the best

1 payment methodology to teach and produce the
2 highest quality and most efficient health
3 care.

4 I and many of the other providers
5 in our networks have delivered care using
6 the four most common systems. These include
7 managed care with outside managers,
8 sometimes out-of-town and out-of-state
9 telling us how to practice, partial
10 capitation, fee for service and finally
11 global capitation with management done by
12 the clinicians caring for the patients.

13 The last one is the only one that
14 we believe will help us reach our desired
15 quality and efficiency goals.

16 Payment systems with outside
17 managers tend to fail since the managers,
18 however well trained and well intentioned
19 are less knowledgeable about the particular
20 needs of my patient.

21 The outside guidance whether from
22 private or public managers also causes
23 resentment and feelings of decreased control
24 in both patients and providers. And

1 inevitably some mistakes are made. This is
2 not to say that there is not a valuable
3 function for insurance companies to -- and
4 governments to help guide us. The second
5 partial capitation system including those
6 for medical home will not address all of the
7 patient's needs and should not be -- should
8 not be the only basis for payment reform.
9 It can provide new techniques and will be
10 helpful but won't give us our goals.

11 The third payment and the one that
12 the fewest resources devoted to prevention
13 and quality fee for service but that is what
14 our doc use most right now.

15 A possible example of over testing
16 is when President Obama received a coronary
17 calcium test which did not change his
18 recommendation to quit smoking or reduce
19 cholesterol.

20 The real risk to him was not the
21 extra radiation which is a year's worth of
22 background radiation in 15 minutes but the
23 fact that the low score can reduce the
24 tendency to actually stop smoking and do the

1 prevention.

2 The last payment methodology and
3 the one with the most to give resources to
4 prevention and quality, global capitation
5 with local clinical managers.

6 Our group in partnership with
7 health plans and hospitals and the other
8 specialty providers in our network have been
9 practicing with these for 12 years. It is
10 also the one that our providers like the
11 most because it affords more time to spent
12 with your patient and pay attention to all
13 of their needs.

14 When the special commission
15 recommended accountable care organizations,
16 we noticed that most of the findings and
17 recommendations for those we had been using
18 for 12 years.

19 If you put quality first and the
20 infrastructure is not achieved, you will
21 achieve both improvements in quality and
22 efficiency.

23 I now believe those that think it
24 will take five years for our state to make

1 the transition to global capitation don't
2 understand the ability of our providers to
3 make the appropriate change. We have seen
4 firsthand the improved health, the reduced
5 cost and improved satisfaction that the ACO
6 type network can bring. All care is
7 managed -- either managed well or poorly.
8 Fee for service systems do not promote or
9 fund the infrastructure for well managed
10 care. Our current global capitation
11 networks better support new PCPs give
12 additional benefit and quality care to our
13 members and save the community money.

14 We have found that the 20 percent
15 of waste is probably true. And we are ready
16 for the rest of our patients to move towards
17 these programs.

18 DOCTOR DONALD GOLDMANN: Good
19 morning. I am Don Goldmann and thank you,
20 Commissioner Morales for inviting me to
21 testify on behalf of the Institute of
22 Healthcare Improvement.

23 I am going to focus my remarks on
24 systems improvements that I think are

1 required to both increase the quality of
2 care and reduce costs. I want to emphasize
3 we are talking mainly about health care but
4 the ultimate goal is improved health and we
5 should be doing a better job, all of us of
6 measuring the health status and functional
7 status and healthy life expectancy of the
8 citizens of the Commonwealth.

9 So I am going to touch on ten
10 points briefly. There is a bit more detail
11 on the posted testimony and I am going to
12 give some cautions and caveats as we go.

13 First, not surprising that I would
14 bring this up -- improved patient safety and
15 reduce harms.

16 Great progress has been made in
17 reducing the rate of costly infections in
18 hospitals through reliable performance of
19 evidence-based practices but there is still
20 room for improvement.

21 Hospitals also need to be working
22 on other avoidable harms such as pressure
23 ulcers, falls, venous thromboembolism and so
24 forth.

1 Now with that said, here are some
2 cautions.

3 Focusing on individual harms
4 certainly is beneficial and lifts our
5 collective spirit when we see progress but
6 it is inefficient and may have significant
7 opportunity costs by shifting hospital
8 resources from other quality and safety
9 issue.

10 Harms prevention needs to be
11 addressed as a system property, part of a
12 broader effort to transform the way we were
13 so that overall rates of harm and mortality
14 actually decrease.

15 Patients want to know that they
16 will be safe when they go into a hospital.
17 They will have no harm period. They don't
18 want or need to understand and pay attention
19 to multiple types of harms when they go in a
20 hospital.

21 Efforts to improve safety should
22 not focus only on ICUs or even the hospital
23 as a whole, the risk of harm extends well
24 beyond the hospital walls.

1 For example, long term intravenous
2 catheters inserted in the hospital carry
3 substantial risk of infection and thrombosis
4 after the patient leaves.

5 Errors of commission are no less
6 important than errors of omission. A 60
7 year old patient who does not receive an
8 indicated colonoscopy and shows up with
9 colon cancer and a patient who has a severe
10 wound infection following colon surgery,
11 both have suffered terrible harms. The
12 second point is reducing hospitalizations,
13 rehospitalizations and Emergency Department
14 visits.

15 The Commonwealth is taking a
16 leadership role in addressing these issues
17 especially re-hospitalizations but there are
18 major remaining challenges.

19 The maximum benefit will be
20 achieved only if care improves across the
21 continuum.

22 Avoiding encounters with acute care
23 systems is a shared responsibility and
24 currently neither hospitals nor providers

1 are rewarded for avoiding
2 rehospitalizations.

3 Patients, especially those with
4 complex medical and social problems must be
5 supported across the care continuum. We
6 should capitalize on promising opportunities
7 to engage navigators, health coaches and
8 community services to support patients
9 outside of the hospital.

10 Some of this assistance can be
11 provided by trained professionals who are
12 not highly paid health care professionals
13 and I think we need to do a better job of
14 leveraging the technologies that are
15 becoming available such as home health
16 monitoring.

17 The patient centered medical home
18 is only a partial answer and by itself can't
19 be expected to magically support patients at
20 home or across the care continuum without
21 other supports beyond the office setting.
22 Realizing the promise of the medical home
23 will require payment reform and a
24 substantial shift of resources to ambulatory

1 care and community services.

2 The biggest cost savings will come
3 from improving the continuity and the
4 quality of the care for the socially and
5 medically complex patients as we all know.
6 And there are many promising approaches to
7 do that but it is equally important to
8 identify and intercept those patients who
9 are less ill right now but will move into
10 the more medically complex and costly
11 category in the short term if we don't do
12 much about them.

13 The third point is reduce the
14 overuse of drugs and technologies
15 particularly by specialists. Even though
16 the terms overuse and waste are distasteful
17 to providers and often misunderstood by
18 patients, the evidence for unacceptable
19 variation and overuse of diagnostic and
20 therapeutic modalities is very clear.

21 As we debate how to reduce the use
22 and reliance on these technologies, I want
23 to acknowledge that there is a bit of
24 beating the technology companies and

1 pharmaceutical companies -- without those
2 advances, things that were achieving today
3 like getting to almost zero in central
4 venous catheter and ventilator associated
5 infections would not have been possible.
6 The stiff catheters and the technology that
7 I used 10 or 15 years ago would not have
8 done the job no matter how much quality
9 improvement we did. So let's be a little
10 realistic on the role of technology.

11 That said, based on the Heller
12 School data there appears to be an urgent
13 need not just to understand the
14 over-utilization of technology but the
15 relationship between price and cost in
16 Massachusetts.

17 Focusing only on utilization which
18 we tend to do may be problematic.

19 There are two issues we need to
20 confront when thinking about the price cost
21 continuum.

22 Even though some technologies have
23 become virtual commodities and volume of use
24 has skyrocketed, price has not plummeted.

1 Health care seems to be a unique industry in
2 which increased supply fuels increased
3 demand without much impact on prices.

4 More importantly, patients have no
5 way to understand the true cost of almost
6 any aspect of care they receive and much
7 greater transparency and simplicity are
8 critical.

9 Fourth, reduce waste in the entire
10 health care system by streamlining care in
11 whatever method you want -- lean -- or I
12 don't care what it is -- it just has to be
13 done.

14 Go into any hospital today or any
15 office and you will see waste due to
16 specimens that are lost, redundant use of
17 drugs, redundant and overuse of procedures.
18 Even worse is the time wasted by providers
19 and patients and the delays they experience
20 in receiving appropriate care.

21 Fifth, deploy HIT in scale. There
22 is abundant evidence that at least
23 theoretically this dramatically reduce costs
24 and improve quality but to achieve

1 meaningful use and improved clinical outcome
2 HIT must be complemented with clinical
3 systems redesign forcing EMR or CPOE into
4 the current flawed delivery system will lead
5 to frustration, rework and even unintended
6 consequences and I hope that the
7 Massachusetts Regional Extension Center that
8 has just been funded by ONC will take this
9 very seriously.

10 We should consider redesigning HIT
11 systems from the perspective of patients
12 rather than providers.

13 Sixth, we should be testing
14 regional solutions to improving quality of
15 care and improving health and controlling
16 per capita costs by paying special attention
17 to the health component because we can tend
18 to silo it since the time horizon is so long
19 to achieving the cost mitigation from
20 improving health.

21 Calculations of health care costs
22 should also include infrastructural things
23 we need to do such as the build in
24 environment, community service, sanitation

1 and foot.

2 Seventh, accelerate tort reform --
3 I won't dwell on that. We all know that
4 physicians are practicing defensive medicine
5 and spending money to do it.

6 Eighth, think of health care
7 expenditures as coming from a common pool of
8 resources, ultimately these costs are born
9 by the individuals living in the community,
10 all of them, but citizens don't think about
11 health care in this way.

12 We have done a relatively poor job
13 of mobilizing the public to think
14 differently about the consequences of
15 sustainable increases in health care costs
16 for both them and their children.

17 Ninth, we need more emphasis on the
18 how of getting from here to there. I doubt
19 that we will achieve our goals magically
20 through legislative mandates, public
21 reporting, pay for performance or pre-market
22 forces.

23 Providers and patients are just
24 going to be need to be coached on how to

1 achieve these aims using systems
2 improvement.

3 And, finally, I don't want to hear
4 about any efforts to contain costs and
5 improve quality that leave anybody behind
6 and the safety net has got to be in front of
7 us every time we discuss this issue.

8 Thank you.

9 MR. MICHAEL BAILIT: Panelists, I
10 just want to remind you of our three to five
11 minute time frame. I have little flash
12 cards here to remind you.

13 MR. PAUL LEVY: Thank you,
14 Commissioner Morales, for inviting me. And
15 to you and to Attorney General Coakley, I
16 just want to express my appreciation for the
17 excellent work done by your staff for
18 preparing for these hearings.

19 It is clear to me from the report
20 prepared by the Attorney General's Office
21 and testimonies submitted by witnesses to
22 the Division that the reimbursement system
23 is broken in Massachusetts.

24 I think most of us would not find

1 it societally appropriate that the amount
2 that physician groups and hospitals were
3 paid for their services would be based on
4 market power as opposed to the underlying
5 characteristics of the population being
6 served and the cost structure required to
7 serve them in that population.

8 There is an insidious result from
9 the current payment system which is that the
10 systems and hospitals that receive higher
11 payments are more likely to recruit
12 additional physicians into their networks
13 thereby causing the greater referral volume
14 to those higher priced systems, and in
15 combination those long term results are in
16 my belief a major contributor to the
17 increasing cost of health care in
18 Massachusetts.

19 As Professor Schoenbaum has
20 mentioned, and I think there are three steps
21 that can be taken to help with that problem.

22 He very perceptively noted that the
23 private payers cannot be expected to solve
24 that problem on their own and, therefore,

1 state action is required.

2 The first type of state action is
3 the type that we started to see here on
4 these charts, some transparencies, some
5 sunshine on the actual rates being paid.

6 A second approach would be to move
7 to all payer prices. This would require I
8 believe the Attorney General's involvement
9 so that anti-trust concerns are alleviated.
10 My proposal on this is that we should start
11 to move all of the providers to the
12 statewide average rate as a start.

13 A final step along that continuum
14 would be the actual rate setting process
15 where it is an administrative law process
16 similar to what is used in the public
17 utility arena.

18 As Professor Schoenbaum has
19 mentioned, Maryland and other states have
20 done that. There are pros and cons of that
21 but it is certainly worth taking a look at.

22 Another area that I think we need
23 to address is the medical arms race problem,
24 the idea that all hospitals or a number of

1 hospitals feel they all have to have the
2 latest equipment and offer all forms of
3 service.

4 We have, as an example,
5 duplicative, highly duplicative programs
6 even in the Boston area in solid organ
7 transplants. There are insufficient organs,
8 livers, kidneys and pancreas' to justify the
9 number of solid organ transplant facilities
10 that exist within five miles of this
11 building today and there and in other cases
12 is an opportunity for state action to simply
13 tell the hospitals, some hospitals that, no,
14 they cannot provide certain services.

15 Getting to the issue of high
16 performance organizations, Don Goldmann said
17 this very nicely.

18 I would like to address it in two
19 respects. One is internal to any given
20 organization -- first, I would like to
21 disagree with Professor Schoenbaum about the
22 idea that there is not a financial incentive
23 under fee for service systems for quality
24 and safety improvements. There are indeed

1 financial incentives for doing so and there
2 are many opportunities to achieve
3 improvements there.

4 Also, as Don suggests, you just
5 can't stop with quality and safety
6 improvements. There needs to be a
7 transformation with the way work is done in
8 the hospital or in a physician's office
9 setting -- that requires a respectful
10 engagement of staff people throughout the
11 organization in the hospital from the
12 transporters and the food service workers
13 all of the way to the neurosurgeons who are
14 empowered and urged to call out problems in
15 the work environment to adopt lean
16 approaches or other approaches like that
17 that are highly respectful of those workers
18 to gain from their experience in pointing
19 out problems.

20 And the final aspect, of course, is
21 an increase in patient and family
22 involvement in the governing and operation
23 of processes of those hospitals.

24 On the external front for any given

1 hospital the relationship between that
2 hospital and affiliated -- and physician
3 groups and community hospitals in its
4 service territory -- I am talking now from
5 the point of view of the academic side are
6 extremely important and that that
7 relationship should be based on mutual
8 respect and information technology
9 connections but should basically be designed
10 to have patients get the care that they
11 should get in the right place whether it be
12 in the community or in that tertiary setting
13 and that can -- that is an important part of
14 controlling long term health care costs in
15 the state.

16 Thank you.

17 MS. BARBRA RABSON: Good morning
18 and thank you, Commissioner Morales, for the
19 opportunity to speak on this panel today.

20 My name is Barbra Rabson and I am
21 the Executive Director of the Massachusetts
22 Health Quality Partners.

23 Efforts to manage costs and improve
24 quality have been going on for decades, but

1 they are too often stymied by the way the
2 health care system is currently organized,
3 financed and, in effect, segmented but there
4 is an emerging consensus, however, that we
5 need good quality measures and we need
6 transparent quality cost data in order to
7 close this value gap.

8 If you can't measure it and report
9 it, you can't manage it. It can't be
10 improved.

11 So the role of my organization and
12 my role is to produce reliable performance
13 information and that is what I will focus my
14 comments on today.

15 The Massachusetts Health Quality
16 Partners is a coalition of physicians,
17 hospitals, health plans, purchasers,
18 consumers, academics, and government
19 agencies that have been first established in
20 1995 by a group of health care leaders who
21 identified the importance of valid and
22 comparable measures to drive improvements.

23 MHQP has a successful track record
24 for reporting trusted healthcare performance

1 information and we provide the information
2 both to the physicians to help improve the
3 care they provide their patients and to give
4 this information to the public to help them
5 better inform their health care choices.

6 To date we have issued eight,
7 excuse me nine public releases of
8 performance information -- eight with
9 physician performance information and one on
10 the hospital side.

11 We believe that transparency plays
12 an important role in making our health care
13 system accountable and provides the public
14 with tools to better inform health care
15 choices.

16 In fact, in a commentary released
17 yesterday by Doctor Lucian Lee who is an
18 internationally recognized leader in patient
19 safety, he argued that of the three major
20 approaches to improving patient safety,
21 regulation and accreditation, financial
22 incentives and public reporting and
23 performance and feedback to health care
24 providers, it is the public reporting that

1 holds the greatest promise.

2 MHQP measures performance in three
3 categories -- measures and tests whether the
4 recommended services are provided. This
5 looks at underuse of measures and makes sure
6 there is preventive screens; measures and
7 tests whether certain services are only when
8 they are appropriate, this looks at overuse
9 of measures and services; and surveys that
10 measure the aspect of care from the
11 patient's perspective.

12 Each of these quality measures can
13 ultimately impact the cost of health care
14 and should be shared both with providers
15 being measured and with the public.

16 And below are some examples of
17 these measures that impact the cost of
18 quality of care.

19 If you look at some underuse
20 measures such as the management of asthma
21 and cancer screening, we can see, for
22 example, how well physicians provide
23 recommended preventive services for
24 colorectal screening. Screening tests can

1 detect colorectal cancer earlier in the
2 cancer as Doctor Goldberg has said and that
3 can lead to more successful treatment.

4 In MHQP's most recent report, there
5 is 43 point range from the highest
6 performance medical group to the lowest
7 performing group. The highest performing
8 group, 92 percent of the time performing the
9 screening when prescribed or recommended and
10 the lowest performing at 49 percent of the
11 time.

12 An example of an overuse measure is
13 to make sure services are used appropriately
14 is physician use of imaging studies when
15 appropriate for diagnosing lower back pain.
16 Most patients with low back pain improve
17 with conservative management and do not
18 require immediate diagnostic study. Yet
19 MHQP's report identified a 45 percent point
20 range in appropriate use of imaging studies
21 for adults with low back pain. The highest
22 performer had a score of 97 percent while
23 the lowest performer was 52 percent. This
24 is clearly a very important measure and we

1 need to narrow this gap.

2 I will say that over time as MHQP
3 measures these, the gaps do narrow over time
4 so it is effective.

5 Finally I want to talk a little bit
6 about patient experience. Patients are the
7 best source of information for certain
8 aspects of care and Steve Schoenbaum had
9 talked a little bit about that.

10 So what MHQP measures is how well
11 doctors communicate with patients. Clearly
12 good communication is strongly linked to
13 positive health outcomes.

14 Patients are more likely to follow
15 prescribed recommendations if they feel
16 their doctors are listening carefully to
17 their concerns and showing respect for what
18 they say. How well doctors coordinate
19 care -- patients are also asked about
20 whether the doctors keep informed and up to
21 date about the care that they are receiving
22 from their specialty physician after referral
23 and 40 percent of the patients reported that
24 their P.C.P. was not always informed and up

1 to date about the care they received from
2 specialists leading to discontinuity and
3 possible poor decisions.

4 Finally, how well patients are able
5 to get timely care and appointments and
6 information -- when patients receive care in
7 a timely way, particularly around chronic
8 diseases -- they may avoid emergency room
9 care and hospitalization.

10 So to conclude, Massachusetts will
11 only achieve the goals we have for a high
12 value health care system if we have reliable
13 and transparent cost and quality measures to
14 drive improvements and behavior change and
15 these measures will need to be linked to
16 payment systems to reward high performance.
17 Thank you.

18 MR. JAMES ROOSEVELT, JR.: I am
19 Jim Roosevelt from Tufts Health Plan and
20 contrary to what you may have read in the
21 State House news in the last few days, I am
22 still President and CEO of Tufts Health
23 Plan.

24 I do want to thank you,

1 Commissioner Morales, for the way you have
2 organized these hearings and I want to thank
3 the legislature and the Governor for
4 mandating these hearings. They are a very
5 important part of our achievement, our
6 historic achievement in bringing about near
7 universal coverage here in Massachusetts at
8 a cost at or below that was projected
9 contrary to what you may have read in the
10 last few days or repeatedly on the
11 Op Ed page of The Wall Street Journal.

12 Tufts Health Plan insures
13 approximately 740,000 residents in the
14 Commonwealth and is ranked the Number 3
15 health plan in the nation by our national
16 quality accrediting body.

17 My testimony will focus on delivery
18 system reform, the drivers of medical cost
19 inflation as well as some solutions and
20 potential challenges moving towards a more
21 efficient and higher quality care delivery
22 system.

23 First, the problem, the report
24 recently released and tremendous work has

1 been done by both the Division with its
2 report and the Attorney General's Office
3 with their report concludes that the period
4 -- that for the period study 97 percent of
5 the total member per month premium growth
6 from 2006 to 2007 was attributable to
7 medical claims. They makes it clear that
8 the only way to reign in premiums increases
9 is by containing medical claims costs.

10 We also know from the reports that
11 unit price or the price we paid per service
12 is responsible for 75 percent of medical
13 inflation, while utilization contributes
14 about 25 percent.

15 The conclusion we draw from these
16 reports is that the solution to cost control
17 will require a more rational alignment of
18 incentives and a possible realignment of
19 prices that results in more affordable
20 access to coverage.

21 We have heard a lot over the last
22 several months and in particular over the
23 last couple of days about the problem.
24 Let's turn to some solutions. The special

1 commission on payment reform recommended
2 that global payments become the predominant
3 form of payment here in Massachusetts.

4 We support that recommendation and
5 concur with the commission that the
6 transition should occur within a period not
7 to exceed five years.

8 Tufts Health Plan has considerable
9 experience with global payments and in
10 particular in our senior products segment.

11 Approximately 22 percent of our
12 commissional, that is non-senior HMO
13 membership is covered under our risk-based
14 arrangement including capitation, however,
15 nearly 100 percent of our Medicare H.M.O.
16 members is covered under these same type of
17 arrangements.

18 We believe that global payments or
19 capitation arrangements when appropriately
20 structured can result in more efficient and
21 higher quality of delivery of care and our
22 results show this.

23 In a recent analysis contracting
24 Medicare advantage plan to traditional fee

1 for service Medicare, Tufts Health Plan had
2 significantly lower rates of avoidable
3 hospitalizations and unnecessary emergency
4 department visits relating in both costs
5 savings and improved patient care.

6 Tufts Health Plan's rates for
7 preventable hospital admissions and
8 preventable emergency room visits are well
9 below the national average for Medicare
10 beneficiaries.

11 It is essential that we acknowledge
12 that global budgets in and of themselves may
13 not correct for the variation in unit
14 price -- at least not in the near term.

15 I believe before we make these bold
16 transitions to global budgets our efforts
17 should be focused on the variation in unit
18 price.

19 There are two proposals currently
20 under consideration by the administration
21 and the legislature which could have an
22 immediate effect on unit price and, thereby,
23 premiums rates and the affordable health
24 plan introduced into the legislature by

1 Chairwoman Stanley who is here and Chairman
2 Moore limits provider prices to 110 percent
3 of Medicare and insurer underwriting
4 surpluses to two percent -- that would
5 result in an average premium decrease of
6 around 22 percent.

7 The affordable health plan is
8 effective in reducing premium rates because
9 it caps unit price at 110 percent of
10 Medicare.

11 This proposal is a short-term
12 solution designed specifically for small
13 businesses that are in dire need.

14 A second proposal House Bill 4490
15 requires carriers to offer a limited network
16 product.

17 I am running out of time so I am
18 not going to be able to go into a lot of
19 detail.

20 I will point out that in eastern
21 Massachusetts limited network products have
22 not been popular. Tufts Health Plan offers
23 one but it has not been widely accepted by
24 members. Neighborhood Health Plan is the

1 only other example in eastern Massachusetts.
2 Fallon Health Plan offers one successfully
3 in central Massachusetts.

4 So, in order to address the
5 problems that we are facing today, we think
6 we have already demonstrated the global
7 budgets can be effective and we believe the
8 five years is a reasonable time frame.

9 I will expand on these thoughts in
10 our answers to questions.

11
12 DOCTOR BARBARA SPIVAK: Thank you
13 for inviting me, a representative of the
14 IPA. I represent Mount Auburn Cambridge
15 IPA. We are a small IPA of 500 physicians.
16 We represent 50,000 patients with global
17 capitation products in Blue Cross, Tufts,
18 our Medicare advantage product is the Tufts
19 Medicare advantage product and Harvard
20 Pilgrim and Fallon.

21 Our physicians see the rest of
22 their patients are paid on a fee for service
23 basis. So they live in two worlds.

24 We have discovered about 15 years

1 ago in doing global capitation that we were
2 actually were taking a ton of risk and doing
3 nothing to manage that risk.

4 So about 15 years ago we began to
5 develop a culture and series of programs
6 would help our physicians both improve the
7 quality of care that they deliver and become
8 more effective in the care they deliver.

9 We believe there are certain
10 elements that have made us more successful
11 than the average IPA. Those include -- not
12 in any particular order -- that we are very
13 primary care doctor-centric.

14 We have a primary hospital. It is
15 Mount Auburn Hospital. They are a risk
16 partner. They share in both the costs of
17 running that program as well as in the
18 benefits when we do well on a global
19 budgets.

20 They as well as the organization
21 are very much geared to promoting the
22 primarily care base of our system.

23 We are organized in a way that we
24 educate our primary care doctors and we help

1 them provide better care.

2 Our programs include a pharmacy
3 management program, a quality improvement
4 program, we are putting in place an
5 electronic health record system that in the
6 next year or so we hope will integrate us
7 more fully and we have a sophisticated case
8 management program that depending on the
9 health status of the patient provides them
10 with either no case management services to
11 the totally healthy but provides quite
12 intensive services for those that are quite
13 ill.

14 We case manage our patients when
15 they are in the hospital as well as when
16 they were in the SNIFS and in the community
17 as well as in acute rehabs.

18 We believe that some of the reasons
19 that capitation failed in the past is the
20 view of both patient and providers was that
21 capitalization was only to limit services
22 and that there was no infrastructure in
23 place to help them improve care and improve
24 quality and improve efficiency.

1 So we have tried to do a different
2 level of service. We have over 40 employees
3 for the 50,000 patients that we manage.

4 Now a good number of those are
5 implementing the electronic health record
6 but that is also as you have seen in the
7 data presented here an important part of
8 making us a more effective organization.

9 We believe that capitation failed
10 because budgets weren't adequately developed
11 and that there was no money or resources put
12 into developing the infrastructure that we
13 have developed.

14 It takes time, money and a
15 commitment by leadership as well as the
16 health plans and the state to develop the
17 kind of community and culture that we have.

18 You have already heard from
19 providers that access to networks is
20 critical. You can't ask for a global
21 capitation unless patients and providers and
22 their hospitals incentives are all aligned
23 to keep the business together in one
24 location in one network.

1 We believe that we have done that
2 by marketing to our specialists who are
3 primary care doctors. So we make it a very
4 important part of our educational process
5 that all of our doctors know what we are
6 doing, and that the quality that we do at
7 our hospitals is equal to or better than
8 what is happening downtown with all due
9 respect to my downtown partner.

10 MR. PAUL LEVY: We are not
11 downtown, we are at Longwood.

12 DOCTOR BARBARA SPIVAK: At the
13 end we believe that global capitation, the
14 development of ACOs, medical homes, whatever
15 way you want to call it, is the right
16 approach but it has to be done carefully and
17 with tremendous thought with aligning the
18 incentives for patients, providers,
19 hospitals and health plans and given the
20 amount of time and resources to develop the
21 kinds of programs that we have developed.

22 MR. MICHAEL BAILIT: Thank you
23 all.

24 So, if you can remember, Jim -- I

1 want to give a little context with the
2 question now.

3 Several of you have talked about
4 the benefits of global payment and as
5 Barbara just spoke to integrating how
6 providers deliver care. But even if that
7 becomes normative in Massachusetts following
8 the recommendations of the special
9 commission, it seems to me that the question
10 I originally asked about the extent to which
11 lack of market competition drives costs and
12 price is still relevant.

13 So let me ask you both in terms of
14 today and prospectively tomorrow, the extent
15 to which lack of competition is a primary
16 driver of pricing costs.

17 MR. JAMES ROOSEVELT, JR.: Let me
18 just start to answer that with actually my
19 favorite health care joke when I first
20 became a health care lawyer back when it was
21 called hospital law before anyone even
22 thought of calling it health care law.

23 A brand new hospital lawyer was
24 walking on a beach and found a bottle and

1 pulled the cork and a genie comes out and
2 says for releasing me you can have one wish
3 and the lawyer being a responsible citizen
4 says peace in the Middle East and the genie
5 says that is much too hard, try something
6 else and the lawyer said, well, explain the
7 American health care system to me and the
8 genie said let's go back to peace in the
9 Middle East.

10 I think that there are many factors
11 as we are hearing here that lead to the
12 situation we are in today. I do think the
13 hidden gem of universal coverage is just
14 what we are seeing that health care costs
15 are now a matter of public interest not just
16 a food fight between providers and payers.

17 Competition has at times in the
18 past played an important role in health care
19 pricing. That has become less true over the
20 last two decades.

21 In the '90s, it is demonstrable
22 that managed care not just because of case
23 management and appropriate use of care, but
24 also because of pricing competition, lowered

1 prices here in Massachusetts and elsewhere,
2 several things then happened.

3 There was a -- there was a
4 significant provider consolidation. There
5 was a change in the legal relationships as
6 there was the backlash against managed care
7 nationally.

8 And in particular things that were
9 referred to in a master stroke of political
10 phrasing as patient bill of rights. And
11 there was not yet the increase in
12 information that we are now seeing. And
13 information is key to competition.

14 There is the risk when you have
15 provider consolidation that information will
16 simply lead to a race to the top on pricing
17 and that is where there is going to have to
18 be a thoughtful and significant, I believe,
19 governmental action as well as strong
20 private sector -- strong private sector role
21 in making pricing -- in negotiating prices
22 to make competition once again a positive
23 factor.

24 Something that takes place in most

1 markets in this country is the use of select
2 networks or limited networks to use the more
3 pejorative term, that is not all providers
4 in every insurers network -- that shifts the
5 leverage and implements competition. This
6 market --

7 MR. MICHAEL BAILIT: Can I follow
8 up?

9 So is a primary reason why you have
10 not been able to negotiate more effectively
11 on behalf of employers and consumers the
12 fact that you can't offer a limited network
13 and you are compelled to include every
14 provider in every network?

15 MR. JAMES ROOSEVELT, JR.: We do
16 offer a limited network actually. We are
17 the only major plan in eastern Massachusetts
18 that does, but two things, our restrictions
19 on that, first of all, in just this market,
20 employers who are the major purchasers of
21 health coverage began about two decades ago
22 to insist on totally comprehensive networks.
23 So that is a market force -- if you are
24 going to try to counter-market forces, you

1 are going to need legislation and
2 regulation.

3 But, secondly, the regulations of
4 the Division of Insurance require a much
5 higher degree of so-called adequacy of
6 networks -- hospitals within a certain
7 number of miles of every members than in
8 most states.

9 So we not only have a consolidation
10 situation, we have a regulatory structure
11 that depresses competition.

12 MR. MICHAEL BAILIT: Okay, I
13 want to zero in and make sure what I think
14 you are saying -- I just want to be super
15 clear on it.

16 It sounds like what you are saying
17 is you can't negotiate lower increases in
18 payment rates or no increases because
19 otherwise, you are told at the negotiation
20 table we won't be part of your network.

21 MR. JAMES ROOSEVELT, JR.: As the
22 globe has documented, Tufts Health Plan put
23 this to the test about ten years ago and
24 came within days of being forced out of

1 business.

2 MR. MICHAEL BAILIT: I want to
3 follow on this topic. Bruce Bullin, a
4 colleague, wrote on his new blog just
5 recently about the insistence of purchasers
6 and consumers on products that include every
7 possible physician, the result of which has
8 been the relentless increase in the price,
9 not necessarily the use of services.

10 Phil, so I want to ask you, you sat
11 on the other side of the negotiating table.

12 So are you essentially able in your
13 negotiations with insurers to some degree to
14 name your price because they have to have
15 you in the network?

16 DOCTOR PHIL GAZIANO: No. Our
17 network isn't big enough and we don't feel
18 the need to.

19 We prefer to partner with
20 hospitals, with the payers and we partner
21 with Tufts and others and our specialists
22 and the members and make it a choice.

23 We feel as was mentioned before
24 that if you do put enough of the resources

1 into the right infrastructure you can manage
2 the care. We found in our 12 years that the
3 predicted 20 percent of health care
4 expenditure being wasted is actually
5 accurate, and that when we reduced
6 unnecessary testing and unnecessary
7 procedures, that the health of our members
8 got better and even their satisfaction got
9 better so because of that we don't feel the
10 need to say to the payers or to the state we
11 need a higher price -- just as long as we
12 have the global capitated budget and we put
13 in the infrastructure ourselves that that
14 worked out fine.

15 MR. MICHAEL BAILIT: Okay.

16 Paul, I would like to follow up with you.

17 So here the market dynamic drives
18 up price. I am interested in your
19 perspective on the extent to which they also
20 drive up costs.

21 Steve referenced a new health
22 affairs piece that suggests that where there
23 is market leverage not only do prices go up
24 but costs go up I know that John Berto who

1 is on MED PAC was here in the fall.

2 It gave him the opinion that lack
3 of competition has related in higher prices
4 that resulted in higher costs basis so a
5 more extensive fiscal plant, equipment and
6 higher wages.

7 To what extent has our lack of
8 competition resulted in us developing a cost
9 base that is particularly high?

10 MR. PAUL LEVY: I haven't seen
11 that article that he referred to so I can't
12 comment on that, but I think perhaps a way
13 of getting at that is the following.

14 We know from the Attorney General's
15 report that there is a wide variation in
16 pricing between -- from the insurance
17 companies among the provider groups, but by
18 the way that is with respect to both global
19 per capitated pricing as well as fee for
20 service pricing.

21 So remember that when you get to
22 your global budget and the need to deal with
23 that variation in pricing.

24 So you would expect that if the

1 contrary were true to what you were saying
2 that the institutions that get the higher
3 prices would have significantly higher
4 margins overtime.

5 In other words, their costs would
6 be about the same but they would have more
7 margin. My impression is that although the
8 higher paid providers had a slightly higher
9 margin, it is not so noticeably higher that
10 it would indicate the best case.

11 In other words, it appears as
12 though they have built into their cost
13 structure the expectation of ever higher
14 prices. So I would imagine that that is in
15 fact the case.

16 I say that -- while I know that we,
17 for example, at BIDMC are both the victim
18 and the beneficiary of the current pricing
19 regime.

20 As I look in the charts that have
21 been submitted, it looks like we are about
22 in the middle of maybe upper middle
23 slightly. I wouldn't like to think that we
24 set our budgets based on what we can get

1 paid exclusively, but I imagine there is
2 certainly an aspect of that.

3 We set earnings targets for
4 ourselves each year based on the
5 reimbursement rates we are expect to get.
6 That in turn influences the degree of
7 staffing, for example, the raises we give
8 our employees and our capital expenditures
9 and so on.

10 In essence, it creates an annual
11 budget for us. We try to set a margin
12 requirement that produces a sufficient
13 return to replace capital in our facilities
14 and so I guess it is just a truism that if
15 you know you have more money coming in, you
16 are likely to create a budget that uses the
17 money that is coming in.

18 MR. MICHAEL BAILIT: I suggest
19 if we want to not only slow down the cost
20 but actually bring down the cost, there
21 would have to be a rather painful way of
22 bringing down the built-in cost base.

23 MR. PAUL LEVY: I think that that
24 is one of the big issues that those

1 providers that have been receiving a much
2 higher reimbursement rates are really scared
3 of because if there is state action to bring
4 them down to the average or someone near the
5 average, they have imbedded cost structure
6 that cannot be sustained and the question of
7 how you manage that transition, assuming you
8 want to do that is going to be equally
9 important to those institutions.

10 MR. MICHAEL BAILIT: Okay. So I
11 want to move a little away now from market
12 dynamics and price and talk about other
13 aspects of delivery system performance
14 because clearly our opportunities to reduce
15 cost growth don't just lie in addressing the
16 current market competition and how it works.

17 So, Don, I would like to ask you a
18 question. In your written testimony you
19 submitted you wrote that we need to reduce
20 waste in the entire health care system by
21 streamlining systems using lean techniques,
22 reliability, science and other discipline
23 matters.

24 I have heard hospital executives

1 from other parts of the country -- from
2 Pittsburgh, from Wisconsin talk about their
3 application of the Toyota production system
4 or of lean processes.

5 Would haven't our hospitals
6 uniformly implemented those systems?

7 DOCTOR DONALD GOLDMANN: Well, as
8 I said, in a slightly offhand way, use
9 whatever system you want to get reliable
10 across the system.

11 I don't think there is anything
12 magical about the lean methodology that
13 isn't expressed by clearly stating what the
14 reliability is all about.

15 Let's give an example. In order to
16 achieve reliability across the system, a
17 couple of things are necessary. One is a
18 clear aim.

19 If we take the care of an
20 individual with asthma or somebody with
21 diabetes or somebody with comorbidities,
22 what is the aim and what is the system that
23 we need to build to achieve the aim.

24 And it turns out if you listen to

1 what Brett James has to say, most of these
2 systems can be articulated in a way that you
3 can actually draw.

4 I don't think you have to do a
5 rapid improvement event or a value screen
6 map to articulate that system. To be
7 honest, it can done relatively easily and
8 there will be clear high leverage components
9 of that system which all need to be done
10 reliably -- not 40 percent of the time or 60
11 percent of the time but in aggregate, they
12 have to be done right almost all of the time
13 and then you have to ask yourself, well, you
14 know, what is the actual affordance or the
15 help that individuals need across the
16 continuum or within a hospital to get that
17 done reliably and it turns out there are
18 fairly simple ways to do this.

19 They need checklists, care
20 pathways, bundles -- there are a whole
21 variety of reliability techniques that can
22 be deployed.

23 MR. MICHAEL BAILIT: I guess, my
24 question is why didn't this happen.

1 DOCTOR DONALD GOLDMANN: I think
2 to some extent, it is happening. This gets
3 to the how that I tried to emphasize. You
4 know, just setting the target and the
5 expression we use a lot is prayer is not a
6 hope -- I can't remember the expression --
7 but you can't just sum it up like of a genie
8 out of a bottle and see what it is going to
9 be. It does takes training. The training
10 turns out to be not that arduous or
11 difficult but you have to have the will to
12 utilize these tools within the system.

13 I will bet that you guys do utilize
14 these tools within your system of care.

15 They aren't pervasive. They aren't
16 necessarily encouraged and the 10 percent of
17 time it takes in a real workday to do this
18 stuff is usually not budgeted for.

19 MR. MICHAEL BAILIT: So how do we
20 make it pervasive? Because, you know, I am
21 a little skeptical that it is pervasive in
22 Massachusetts right now.

23 I mean I know I have heard the CEO
24 of Cedar Care was caught and bragged about

1 how he takes 25 million dollars a year of
2 his system by doing lean.

3 But I don't know hear that, you
4 know, uniformly out of the Commonwealth
5 today. So what do we have to do to become
6 more efficient?

7 DOCTOR DONALD GOLDMANN: Let'S
8 not confound the savings that occur across
9 the continuum in a system that is integrated
10 and where costs actually follow the
11 improvements in care.

12 So quality improvement doesn't save
13 costs for a hospital if the current payment
14 system exists.

15 You know, it is got to be societal
16 costs we are talking about now and societal
17 costs aren't reflected in anything that I
18 could see in the current payment system.

19 So that is a confound issue.

20 You know, it turns out actually
21 that most providers do want to get good
22 outcomes and the processes of care that are
23 required are fairly well known for many
24 conditions.

1 It really, I think requires a clear
2 vision commitment of leadership and the
3 people that they have in the organization
4 who are trained to do these relatively
5 simple things.

6 That doesn't really get in your
7 question. There is no magic bullet for
8 this.

9 Currently I don't see throughout
10 most organizations the leadership and
11 commitment to that kind of thinking and it
12 is certainly not supported by the current --

13 MR. MICHAEL BAILIT: So do we
14 need financial incentive and we referred to
15 advocacy for APOs and global payment -- is
16 that what is needed to create the impetus to
17 become more efficient.

18 DOCTOR DONALD GOLDMANN: Yes, I
19 certainly think that that will be helpful
20 but if I walk into Cincinnati Children's
21 Hospital right now, and I ask you to show me
22 evidence that they can prove the outcomes
23 from the children -- she can pull from her
24 briefcase literally 14 or 17 run charts

1 showing consistent improvement all done by
2 simple reliability systems redesign with
3 some coaching, and I don't think she is
4 telling me Cincinnati Children's Hospital
5 has just saved a bundle of money or this is
6 our economic driver.

7 She will say that on 17 conditions
8 that effect children -- those that account
9 for 80 percent of the care that they give,
10 they can show sustained improvement using
11 relatively straight forward reliability
12 systems improvement.

13 So, yes, it is a big help to get
14 the will but it isn't going to necessarily
15 help with the execution.

16 MR. MICHAEL BAILIT: Paul?

17 MR. PAUL LEVY: I have to
18 disagree with your assumption there,
19 Michael.

20 MR. MICHAEL BAILIT: Okay.

21 MR. PAUL LEVY: Let's take the
22 general application of lean principals of
23 6 sigma to other industries which by
24 definition are on a fee for service basis

1 whether it is automobiles or steel or
2 whatever, you would see the same variation
3 in the adoption of lean approaches in those
4 industries as we would in the hospital.

5 Steve Spear writes about this. He
6 talks about the anomalies in different
7 industries where they have chosen to invest
8 in lean process improvements and how those
9 companies have come to make those decisions.

10 So it is not a pre-condition of
11 investing in lean and those things to have
12 global payments. As I said to you before --

13 MR. MICHAEL BAILIT: Okay, what
14 are the barriers?

15 MR. PAUL LEVY: The barriers are
16 the leadership of the organization and the
17 commitment to doing it and the governance of
18 those organizations and I would say in a
19 market like Massachusetts, to your point
20 before is if you are overpaying certain
21 providers they have absolutely no incentive
22 to address their cost structure because they
23 are going to be more successful by spending
24 more, their network will continue to grow,

1 their referrals will continue to grow
2 notwithstanding their cost of business.

3 So to the extent that we have a
4 disparity in what people get paid for doing
5 exactly the same work in this state it works
6 against the goal we have stated. Whether
7 that disparity is in the form of global
8 payments or fee for service payments, the
9 same result obtains.

10 MR. MICHAEL BAILIT: It sounds
11 like it is just not disparity because you
12 could have uniform payment at a high level
13 and that wouldn't necessarily create a
14 compelling business case to become lean, so
15 it seems to me that what we are talking
16 about is having some level of economic price
17 pressure to motivate an organization to
18 become more efficient.

19 MR. PAUL LEVY: Yes, and what
20 that level is, of course, remains to be
21 seen.

22 My suggestion is, well, let's start
23 with the average rates that exist in the
24 state as a place to start and see where that

1 leads would be a way to go.

2 We know there are hospital
3 physician groups that are underpaid relative
4 to the value that they provide.

5 If you look at the chart over here,
6 if I were Ellen Zane at Tufts Medical
7 Center, I would be mighty upset that her
8 rates are what they are given her case mix
9 index relative to BIDMC and relative to
10 other people. It is just not right. There
11 is no societal basis for what she and her
12 hospital are getting paid. It is contrary
13 to the public interest.

14 MR. MICHAEL BAILIT: Okay,
15 Barbra Rabson, I am going to ask you about
16 transparency. You, Don, Jim and Paul have
17 all pointed to transparency as a fundamental
18 problem.

19 I want to clarify exactly why it is
20 a problem. And is lack of transparency
21 really causing high and increasing payment
22 rates?

23 I mean it is clearly having some
24 transparency gives cause for us to want to

1 focus on the topic but is lack of
2 transparency the driver of costs.

3 MS. BARBRA RABSON: No, no, I
4 think the lack of -- the driver of costs is
5 this misaligned incentives because if you
6 are paid to do things that don't need to be
7 done and then you do them and there is a lot
8 of waste -- so that is the driver.

9 I think what transparency does is
10 introduce accountability both on the quality
11 and the cost side and so you are able to see
12 for the first time, you know, the work at
13 the A. G has showed transparency and
14 competitive costs given similar levels of
15 quality creates the question that Paul is
16 talking about.

17 And so it raises the dialog from a
18 policy perspective it is really important.
19 From a perspective of consumers we have done
20 a lot of work with consumers. We have been
21 quite frustrated, in fact, with the lack of
22 engagement with consumers about the
23 accessing our information or using it to
24 make decisions and part of the problem is

1 that we are not given consumers what they
2 want and because it is too hard to collect
3 and so we give them what we have.

4 So a perfect example is we ran some
5 focus groups in Worcester around a group of
6 consumers about the measures that MHQP has
7 on their website. So we showed them the
8 mammogram testing -- how often do women get
9 their recommended mammogram and so a woman
10 looked at it and she said, okay, so what you
11 are telling me is that Fallon Clinic, 95
12 percent of the time, women who were
13 recommended for a mammogram get the
14 mammogram here -- and we said, yes, and she
15 said, well, I don't care about that. I get
16 mine. So why are you telling me that, you
17 know, a societal thing -- she understood
18 from a public health perspective that
19 mammograms were important but for her
20 personally she wants to know if she goes to
21 get a mammogram, she is going to be treated
22 well and if she has bad results, she is
23 going to get them immediately and that if
24 she has to go through treatment that it is

1 going to be done well and she will survive.

2 So part of the challenge around
3 transparency and quality side is we don't
4 yet have the right measures that resonate
5 with consumers so we are expecting them to
6 act on what we give them which is a start,
7 you know, but there is a lot we need to do.

8 MR. MICHAEL BAILIT: So if we
9 want to solve our cost problems arming
10 consumers with information on cost and
11 quality might be a worthwhile aim but it is
12 not going to necessarily be a key tool for
13 addressing costs.

14 MS. BARBRA RABSON: It is part of
15 the puzzle.

16 I mean the thing is we have to
17 engage consumers because we can't expect
18 physicians to take care of health.

19 Consumers have a huge role --
20 patients have a huge role in taking a role
21 in their health and if they don't engage, we
22 won't get the outcomes we desire.

23 So there is a whole continuum in
24 what we want consumers to engage in. First

1 and foremost, in their own personal health
2 and health care and their family and the way
3 to sort of grow your awareness around that,
4 is you know am I going to the right
5 facility, am I seeing the right doctor who
6 can take care of what is important to me and
7 am I being treated the way I expect to be
8 and there is all kinds of relationships and
9 so forth.

10 The continuum is really key. No
11 where in the country has this happened yet.
12 MHQP participates in regional coalitions
13 with other sister coalitions across the
14 country and we are all grappling with it
15 and, in fact, we have just got part of the
16 Robert Lee Johnson funding of community
17 addition that really focuses on consumer
18 engagement and it will be part of that
19 family to focus on this issue but it is one
20 that is going to take sort of a like public
21 health issues, a 360 approach in terms of
22 how you deal with it.

23 MR. MICHAEL BAILIT: Okay, Don,
24 do you want to respond?

1 DOCTOR DONALD GOLDMANN: You
2 know, I don't know the ground rules here but
3 I think you have made an extraordinary
4 point.

5 When I talk about transparency, I
6 was only talking about what things really
7 cost. I was talking from an individual
8 point of view.

9 There is a chasm between aggregate
10 measures reported publicly and the
11 individual patient family centered care
12 people experience when they go somewhere.

13 I actually think that measurement
14 has four conceivable purposes and I will
15 tell you what they are.

16 The first is punishment of some
17 sort or reward -- namely pay for
18 performance.

19 And the second which is consumer
20 choice -- we have very little evidence that
21 aggregate measures effect consumer choice.

22 Third is improvement which, of
23 course, is exactly what I think measurement
24 ought to be used for 90 percent of the time.

1 And the fourth is research and
2 those are the four ways in which measurement
3 could be used and it is really important to
4 think what the experience is that the
5 patient and the family undergoes with
6 respect to the time measures that you are
7 asking to be transparent.

8 You are absolutely right when a
9 patient goes in a clinic, if it is truly a
10 patient family centered place, what they
11 want and truly need will be discussed and
12 done if they are not engaged, not mobilized,
13 not aware, then you will have to rely on the
14 aggregate average performance which is
15 generally not high enough at least for my
16 tastes.

17 MR. MICHAEL BAILIT: Jack, I
18 would like to ask you a question now.

19 Steve Schoenbaum in his
20 presentation shared some information that
21 said that organization is enabler although
22 not a guarantor of higher performance and I
23 am interested in to what extent you think
24 that the manner in which providers in the

1 Commonwealth are organized or not are
2 contributing to our high costs and high cost
3 growth and if there needs to be more
4 organization, is it an organization of
5 physicians or is it an organizations of
6 physicians, hospitals and others perhaps.

7 DOCTOR JACK DUTZAR: Well, I am
8 not sure I can comfortably respond to the
9 first part of that question.

10 You know I am a longstanding
11 believer in the aggregation of physicians
12 especially in the context of multi-specialty
13 group practices and for the reasons I talked
14 about in my testimony.

15 It creates an opportunity for us to
16 invest in a system of care that are the
17 kinds of things that allows us to move the
18 patients through their process of their
19 health and health care experiences from
20 hospital to their home and medical office.

21 We are in a position, for example,
22 as a reasonably good sized multi-specialty
23 group to invest in very sophisticated health
24 information technology that allows us to

1 connect with our patients not just in the
2 context of the office visit, but in the
3 context of internet access with them
4 individually and all the rest.

5 We haven't seen the full payoff in
6 terms of that level of aggregation and
7 organization in terms of the cost reduction
8 partly because of the initial investments
9 are so high and the training and cultural
10 changes are so daunting but we believe in
11 the long run we ultimately will -- that the
12 relationship between our group and our local
13 hospital is recognized by both our hospital
14 and us as being inadequate and not in good
15 service to our patients.

16 And we are -- the leadership of
17 both organizations is collectively committed
18 to that.

19 Over the course of the long period
20 of time I have been doing this, the hospital
21 has always been the center of the health
22 care universe except for patients -- most
23 patients are not in hospitals and most
24 patient's experience with their health care

1 doesn't occur in that environment at least
2 with any kind of regularity or frequency.

3 It is a key aspect and important
4 element and I believe that the concepts of
5 managed care, the concepts of capitation
6 will drive a level of integration and
7 organization and whether we call them
8 accountable care organizations or not it is
9 ultimately key.

10 The hospital -- the other issues
11 that I would relate is over the years I was
12 trying to understand what would reduce
13 costs -- patients costs issues are often
14 changed or driven up in the transitions,
15 transitions between the medical office and
16 the hospital and the hospital back to home
17 and then surrounding -- and often patients
18 fall through the cracks with inadequate
19 information, inadequate follow up and once
20 again in organized systems like ours, we can
21 invest as some of the others that testified,
22 we can invest in systems to help support our
23 patients throughout those processes and do
24 our jobs.

1 We are not doing the community as
2 good a job today as I believe we can do --
3 but we do have that opportunity.

4 MR. MICHAEL BAILIT: Let me ask
5 about some of the market implications of
6 having more organized systems, whether they
7 be health care organizations or the other
8 name.

9 I know the special commission on
10 health care payment has some concern that
11 while there would be potentially great
12 benefit in creating greater organization,
13 that there might be some pricing
14 locations -- in fact, the commission
15 recommended that there be an oversight
16 authority created specifically to monitor
17 that regulatory power.

18 And I know that the Attorney
19 General's office has expensed concern as
20 well.

21 Is there a real threat that
22 efficiency gained through tighter levels of
23 integration and organization -- that would
24 potentially result in savings would be given

1 away because the decreased competition would
2 result in inflated pricing.

3 DOCTOR JACK DUTZAR: I think size
4 is relevant in that. I am not sure if the
5 level of integration coordination is.

6 MR. MICHAEL BAILIT: Let's say
7 that in Worcester County there is one
8 accountable care organization, that the
9 level of integration and consolidation
10 became that big.

11 So under that scenario, could it be
12 that whatever efficiencies are gained
13 through that organization and maybe they are
14 doing everything lean and eliminating waste
15 but they can turnaround to Jim or any other
16 payer and say, okay, we are the only ones in
17 Worcester County so here is what you are
18 going to pay us -- is there a potential that
19 the savings that we obtain are going to be
20 giving away on price.

21 DOCTOR JACK DUTZAR: Well, I
22 guess the theoretical answer -- the short
23 answer to that would be, yes, but that is
24 never going to happen and what I do think is

1 that there are opportunities for more
2 integration among existing infrastructures.
3 We have three basically reasonably organized
4 systems in the central area directly around
5 Worcester and even up in the north part of
6 the county in Leominster there are small
7 integrated medical group and hospital
8 activities that do that do a darn good job
9 even though they are our competitors.

10 MR. MICHAEL BAILIT: Can I ask
11 you why you think it won't happen because
12 this graph or this chart up here suggests
13 that it happens today with hospitals, so why
14 wouldn't it happen with accountable care
15 organizations?

16 DOCTOR JACK DUTZAR: Well, I
17 assume that both the Federal and the state
18 level there would be opportunities for
19 oversight at that level of aggregation and
20 market account.

21 I mean that happens because of fee
22 for service, the term there. If you set
23 your pricing as the federal government does
24 based on essentially a county rate and state

1 rate and adjust it for severity, then it
2 wouldn't matter how big my ACO is, the, you
3 know, adjusted payments should not be based
4 on, you know, whether I have a big ACO or
5 not a big ACO and whether or not you have
6 the title ACO, most of the components are,
7 in effect, now in global capitation, H.M.O.
8 type of networks.

9 The risk that the other thing to
10 think about with regulation is you probably
11 do want to ensure that networks aren't too
12 small because if you have a very small
13 network of physicians and they are not
14 experienced in this type of care, then they
15 can lose a lot of financial resources and go
16 under the members they serve can be ill
17 served, so you may want to have a minimum
18 bar for some of these.

19 We have found that the -- that
20 those that are in those networks are going
21 to have to teach the others, but actually
22 the transaction to more of the accountable
23 care organizations will create expertise and
24 systems that would actually keep

1 Massachusetts in the forefront of the
2 nation.

3 MR. MICHAEL BAILIT: Okay, what
4 I am hearing from both of you is that there
5 would be a need for either the definition of
6 some parameters for how global payment rates
7 would be set and for some level of
8 regulatory oversight to protect against
9 that.

10 MR. JAMES ROOSEVELT, JR.:
11 Michael, could I just comment on that?

12 MR. MICHAEL BAILIT: Sure.

13 MR. JAMES ROOSEVELT, JR.: Our
14 experience with our Medicare advantage plan
15 is that size makes a difference but there
16 are various ways to compensate for size to
17 achieve for success and integration.

18 So for example as Doctor Spivak has
19 described -- I am using the last names
20 because I am sitting between two Barbaras.
21 As she has described, they are among the
22 best well organized and have the best
23 resources that they have acquired to manage
24 and integrate, but we also have within our

1 Medicare preferred plan much smaller groups
2 of physicians and we has a health plan
3 provide many of the tools that MICIPA does
4 on its own. I think MICIPA does it to a
5 greater extent but smaller groups of
6 physicians can be very successful if they
7 have the tools to monitor overuse and
8 underuse of care, if they have the
9 guidelines.

10 And so I think it is a combination
11 of size, of resources and tools that are
12 used and of geographic dominance to get back
13 to your question -- if an accountable care
14 organization over a large metropolitan area
15 is dominant, it has a different effect on
16 the pricing systems.

17 MR. MICHAEL BAILIT: Okay. I
18 want to go to Barbara, and I want to ask you
19 a question, Barbara, on the topic of waste,
20 so Phil talked about 20 percent.

21 There are some research estimates
22 that suggest that 30 percent or more of all
23 health care services that are delivered
24 provide no benefit to the patient and, in

1 fact, sometimes harm the patient and, in
2 fact, just this month the American College
3 of Radiology published a study. They looked
4 at the use of C.T. scans and MRIs and found
5 that 25 percent were inappropriate.

6 So I would like to ask you what are
7 the most contributing reasons to overuse of
8 services?

9 DOCTOR BARBARA SPIVAK: We think
10 that there are several reasons why there is
11 overuse not the least of which is the
12 malpractice system that we have today which
13 encourages physicians to do everything they
14 can immediately to avoid the risk of being
15 sued later on.

16 We also believe though that often
17 physicians don't order the right test the
18 first time because they don't really know
19 what the right test is.

20 So I think one of the things we
21 have done in our IPA is to encourage people
22 to ask questions and when, for example,
23 after physicians order an MRI have
24 radiologists actually make sure that they

1 have a history that says what the MRI is
2 really looking for and if that MRI is not
3 appropriate and is not the best test, they
4 will actually call the physician and say we
5 reviewed this -- we recommended that you do
6 an ultrasound first and I think by trying to
7 teach people to do the right thing first,
8 you can really save and improve utilization.

9 Pharmacy is a huge example of waste
10 because there are at least 10 drugs out
11 there for every problem you want.

12 And many of them are generic and
13 cheaper than some of the ones that have not
14 yet reached that status, but the ones that
15 the pharmacy companies go out to and give
16 lunches for are the ones that doctors tend
17 to prescribe.

18 So by having a pharmacy program at
19 our IPA we have encouraged the use of
20 generics and we have kept our trends, our
21 cost trends and our PMPM costs down
22 dramatically.

23 So I think by educating doctors and
24 educating providers, we can really prevent a

1 significant amount of waste.

2 I also think that one of the things
3 that we have to realize as we are talking
4 here is that patients have to understand
5 that as well.

6 When a doctor is sitting in the
7 office, it is the doctor/patient
8 relationship that is primary and too often
9 the health care system doesn't help patients
10 to do the right thing.

11 So if you look at what we have done
12 to try to control costs from the patient's
13 point of view there has been tiering --
14 well, tiering doesn't do a whole lot -- if
15 you are critically ill and you are seeing a
16 tier 3 specialist because you have multiple
17 sclerosis and your neurologist is tier, we
18 have now taken our sickest patient and made
19 them pay higher co-pays because they have to
20 see a doctor more often.

21 Tiering hospitals haven't
22 really moved patients because people really
23 think that they are getting the best care by
24 going to the more expensive hospitals.

1 And high deductibles don't do it
2 because it really prevents patients from
3 getting necessary care as often as it
4 prevents them from getting unnecessary care.

5 So I think one of the other pieces
6 that we have to address is aligning
7 incentives not just for the providers, the
8 hospital and the physicians, but we really
9 have to find a way of engaging the patients
10 so that they understand that we are
11 providing better care not just less
12 expensive care but that we are trying to
13 provide higher quality better care.

14 MR. MICHAEL BAILIT: Okay.

15 ASST. ATTORNEY GENERAL LOIS JOHNSON:
16 If I could follow up on that, one of the
17 things you mentioned, Doctor Spivak, in
18 terms of your success was that the
19 integration took time and it took money and
20 you also highlighted the importance of
21 networks and just to follow up of what you
22 were talking about of engaging the patient,
23 can you talk about how you have used
24 networks or encouraging patients to stay

1 within your network as part of your
2 strategy?

3 DOCTOR BARBARA SPIVAK: Well, our
4 strategy has been -- we have a community
5 hospital, Mount Auburn, which provides a
6 huge range of services from open heart
7 surgery to neurosurgery to vascular surgery
8 and our way of controlling costs, one of the
9 ways has been to try to keep as much of the
10 business that can be done and performed at
11 our hospital with our specialists within our
12 network.

13 And the way we have done that is by
14 educating our primary care doctors what our
15 own doctors can do.

16 So by being a small hospital, that
17 has helped us because the doctors all know
18 each other.

19 So when I have a patient who needs
20 surgery, it is much more effective for me to
21 be able to say that I know the vascular
22 surgeon that I am sending you to, he is
23 terrific and I am going to call him when you
24 leave and make the referral.

1 I think that helps patients feel
2 comfortable that their primary care doctor
3 who presumably they are seeing me because
4 they trust me also will trust the referrals.

5 I think that development of
6 networks is going to be key for any future
7 global capitation system that you develop
8 because I can't control utilization costs
9 when patients go outside of my hospital.

10 MR. MICHAEL BAILIT: I want to
11 ask a couple of questions that have been
12 submitted by the audience.

13 The first one, well, I will say
14 thematically with the point that Barbara
15 touched upon.

16 I guess, Jim, this would be for
17 you -- resistance to limited networks by
18 employers stems from the fact that there is
19 not a great price differential between
20 limited network products and other products.

21 Is the Tufts product price
22 significantly lower or is it marketed
23 adequately?

24 MR. JAMES ROOSEVELT, JR.: To

1 answer both parts of that question, the
2 pricing difference -- although I don't have
3 the exact numbers is approximately 25
4 percent -- so I think that that is a
5 significant difference.

6 MR. MICHAEL BAILIT: Is that
7 available to both large and small.

8 MR. JAMES ROOSEVELT, JR.: Well,
9 that goes to the second part because is it
10 marketed adequately.

11 In order to get provider
12 participation, we had to -- to assure
13 providers that it will be offered only to
14 individuals and those small businesses who
15 were eligible to purchase through the
16 connector.

17 So it is not marketed to larger
18 businesses.

19 Now I will tell you that for the
20 roughly three years that we have had the
21 limited network, I have tried to promote, to
22 broker interest in it because that is what
23 could bring a change -- demand could bring a
24 change in those limitations -- never had any

1 positive take up on that until last month.

2 Last month at our semiannual broker
3 meeting, brokers were all over me -- why
4 can't we sell the limited network to our
5 groups.

6 And so I think that there is
7 whether it is because of information or
8 actually I think -- I think a lot has
9 changed because of the general economic
10 situation in the country.

11 When we did health care reform in
12 2006, the Massachusetts Associates of Health
13 Plans commissioned a study that demonstrated
14 there would be a two to four percent
15 increase in premiums because of the merger
16 of the small group and non-group markets --
17 two to four percent increase for small
18 businesses even though there was a 20 to 25
19 percent decrease for individuals.

20 Everybody in the economy of 2006
21 said two to four percent -- who cares about
22 that. Now that is a big issue. So I think
23 we are entering a different period and
24 indeed the participation level which is

1 about 2,500 people in our limited network,
2 for the last two years has caused an
3 internal discussion in our plan -- why are
4 we putting the resources into keeping this
5 going and I have taken the position which
6 since I get more votes has prevailed that we
7 should hang in there, the market is going to
8 come to realize that cost and quality can be
9 combined as positive factors.

10 MR. MICHAEL BAILIT: Paul.

11 MR. PAUL LEVY: I think one of
12 the reasons Jim and others had trouble
13 selling limited networks is because those
14 business subscribers who are acting on
15 behalf of their employees, find that their
16 employees believe that the reputation of the
17 hospitals in the geographic area and I think
18 it is very sad that that reputation has no
19 basis in fact for the reasons Barbra Rabson
20 was talking about before. We do not have
21 sufficient transparency of clinical outcomes
22 to be able to say to potential business
23 subscribers and their employees is the
24 reason we have not included hospital X, Y

1 and Z is because their results are no better
2 or worse and because they are 15, 20 percent
3 more expensive.

4 In the absence of that data and I
5 am not saying that data would be used by
6 consumers in making a choice day to day
7 would be used by subscribers in making a
8 choice of an insurance product does not
9 exist in the public domain.

10 The data that Art put out there the
11 CMS data and so on are two years old and
12 they are based on administrative data and
13 they are not really useful in a marketing
14 sense I would guess although Jim can tell us
15 better than that and I think it is a
16 legitimate function of the state government
17 to make that data more accessible.

18 In my conversations with my
19 colleagues around the Boston area and my
20 attempt to have them agree to publish this
21 kind of data jointly, that has been not
22 acceptable on the part of -- and I think it
23 is because they fundamentally understand
24 that if the data were made available, the

1 emperor would have no clothes and it would
2 be seen that there is essentially not a big
3 difference among the quality of service
4 provided to the public by the major
5 hospitals in the Boston metropolitan area.

6 MR. MICHAEL BAILIT: Thank you,
7 both. I think the next one is for you,
8 Jack.

9 While no one can argue that
10 integration is likely a good thing, the
11 reality is that our two oldest largest
12 integrated systems in Massachusetts
13 including Fallon have the highest total
14 medical expenses in their geography, when
15 could we expect to harvest savings from
16 those models?

17 DOCTOR JACK DUTZAR: Well, I am
18 not sure I accept the premise of that
19 question nor do I fully understand the
20 concept of it. Maybe you could help me with
21 that.

22 MR. MICHAEL BAILIT: Well, I know
23 the factual basis for the highest total
24 medical expenses, but there seems to be a

1 sense that where we have integration we are
2 not achieving the efficiencies or savings
3 that we might.

4 DOCTOR JACK DUTZAR: Well, when
5 this whole process started, I thought it was
6 going to be extraordinarily interesting to
7 us because we don't know where we come
8 relative to other care delivery systems in
9 terms of their total costs of care.

10 I actually tried to get the folks
11 to share with me which of the bars we
12 represented on the list and they were
13 unwilling to do so quite appropriately.

14 What I would tell you is that we
15 have indirect evidence that the statement
16 made by the question is inaccurate.

17 The indirect evidence is that all
18 four of the major health plans in the
19 Commonwealth that are visibly actively
20 interested in developing their own network
21 product with us, the existing narrow network
22 product we offer has been meeting the market
23 by 10 to 20 percent and brought a range of
24 the commercial market in central

1 Massachusetts for many years, we deliver
2 \$20.00 to 25 to \$30.00 per member per month
3 lower costs for pharmaceuticals than the
4 average for the Commonwealth, and so I am
5 not sure -- I mean I just don't except the
6 premise.

7 ASST. ATTORNEY GENERAL LOIS JOHNSON:

8 For clarification and for your --

9 DOCTOR JACK DUTZAR: -- my
10 curiosity?

11 ASST. ATTORNEY GENERAL LOIS JOHNSON:

12 In the Attorney General's full
13 report we do have some charts that track the
14 total medical expenses of large physician
15 groups and we identify which provides are
16 globally paid or paid some risk based
17 contract versus fee for service and you can
18 see that the method of payment bears no
19 relation to the level of TME and that some
20 lower paid providers do significantly have
21 significantly higher TME than their fees for
22 service.

23 DOCTOR JACK DUTZAR: I read that
24 but for me the complexity never goes away.

1 Because one of our major payers or our
2 primary payer at some point, we have risk
3 adjusted data that suggested our commercial
4 enrollees are about 2.0.

5 So we are talking about absolutely
6 dollars in a relative --

7 ASST. ATTORNEY GENERAL LOIS JOHNSON:

8 This is risk adjustment.

9 DOCTOR JACK DUTZAR: Some of that
10 has been uncertain whether it is risk
11 adjustment or not.

12 When we looked at all of the data
13 that we got back and information in the
14 possess, we were very interested in it and
15 ultimately, I don't know how to reconcile
16 the fact that the payers are interested in
17 working with us -- more because from their
18 perspective we are supposed to -- we appear
19 to be delivering both on premiums and total
20 cost of care and the data that is presented,
21 I just don't have a way to do that.

22 MR. MICHAEL BAILIT: Phil --

23 DOCTOR PHIL GAZIANO: We have
24 information that 80 percent of the members

1 that are network and/or physician group care
2 fee for service and 20 percent are global
3 capitation.

4 Even in our network the 20 percent
5 in global capitation for seniors do use 20
6 percent less and have higher quality of
7 scores for dollars because of that
8 integration.

9 Now the 20 percent savings -- part
10 of that has to go back to support those
11 services and so it is not all profit.

12 With our commercial we were
13 surprised to find that before we started
14 global cap that the same group of patients
15 we had a cost inflation above the state and
16 county average of 8 percent and as soon as
17 we started capitation on the same patient,
18 we had a medical inflation rate total dollar
19 of 1 percent -- same severity, same number
20 and entire quality scores.

21 MR. MICHAEL BAILIT: I want to
22 introduce a new question for both Phil and
23 Jack, and that is regarding
24 re-hospitalizations and E.R. visits, both

1 commonly looked at as opportunities to
2 improve both quality and reduce costs.

3 In Massachusetts for the
4 commercially insured population about 5
5 percent of hospital costs would be
6 admissions. For the Medicare population, it
7 is more than double that.

8 And we know that a high percentage
9 of ER visits are potentially avoidable.

10 Why haven't we been able to solve
11 those problems? We have known about them
12 for some time but we continue to have pretty
13 high rates of both?

14 DOCTOR PHIL GAZIANO: Again the
15 problem is, we learned six years ago that if
16 you have an integrated disease management
17 problem, you can prevent admissions but
18 under fee for service nobody pays for it.
19 Under global capitation it is paid for.

20 We just got the date on our
21 admission rate where the state average for
22 seniors is a little over 20,000 per year
23 and, in fact, with Tufts, our partner, the
24 goal was below 10 and our group came in at

1 9.8. We were one of the only ones under 10.

2 We got the readmission rate down
3 because of our integrated disease management
4 program. We also were is able to track, you
5 know, reduced overall hospital day and
6 admissions and dollars.

7 Before we started our disease
8 management program just as with any
9 medication population the top 3 percent used
10 50 percent of the dollars.

11 As soon as we started that within
12 two quarters it dropped to 42 percent and it
13 has remained there and that, for our
14 network, has saved a few million dollars.

15 We also found that the satisfaction
16 of those sickest of the sick, those 300 that
17 we have on our disease management program
18 goes way up. They are happy with the extra
19 phone calls, doctor visits, home visits that
20 we put in to do that and, in fact, when one
21 of them heard that she was going to have to
22 give up her Nurse Nancy coming into the
23 home, she quickly paid up the premium. So
24 they are finding it a benefit.

1 MR. JAMES ROOSEVELT, JR.: We
2 appreciated that too.

3 MR. MICHAEL BAILIT: Barbara
4 Spivak --

5 DOCTOR BARBARA SPIVAK: I would
6 like to agree with that. We have found that
7 making sure that patients have a visit with
8 their primary care doctor anywhere from 3 to
9 7 days after discharge from a facility is a
10 key factor.

11 We actually monitor the number of
12 primary care visits per year and when groups
13 fall below a certain amount, we actually
14 meet with them and encourage them to see
15 their patients more.

16 We have found a direct correlation
17 between when groups fall below a certain
18 amount, we actually meet with them and
19 encourage them to see their patients more.

20 We found a direct correlation
21 between the groups that see their patients
22 more in the office have a lower based
23 hospital rate and a lower re-admission rate
24 and a lower ER use.

1 So just the fact that we are
2 encouraging with primary care to be actively
3 involved is a major effort.

4 But it also clearly decreases
5 costs.

6 On top of that I think like Hampden
7 County all of our high risk patients are in
8 case management programs where the case
9 managers call and make sure that patients
10 keep their appointments and make sure they
11 are taking their meds.

12 Every patient that is discharged
13 gets a call from the case manager within
14 again depending on the severity, 24 hours or
15 72 hours after discharge to make sure they
16 have their meds and the meds are correct.
17 We have a program where we send either a
18 nurse practitioner, a nurse or even a
19 pharmacist into the home to make sure that
20 meds are correct and being taken correctly.
21 So meds that should be taken without food
22 are taken without food and not taken
23 together with others, etc.

24 All of that I think costs a great

1 deal to maintain those systems. The
2 patients are clearly feeling better about
3 the care they receive. They are getting
4 better care and at the end of the day
5 hopefully the costs to the system are less.

6 MR. MICHAEL BAILIT: Barbara,
7 what are the greatest barriers that you face
8 to reducing health care costs and improving
9 quality?

10 DOCTOR BARBARA SPIVAK: The
11 greatest barriers we have are that the fee
12 for service world doesn't pay for us to do
13 what we need to do.

14 When we have patients who are on
15 their own, who are on straight Medicare, it
16 is much harder to provide them with the
17 services that they need.

18 The rules of the visiting nurse are
19 that they are happy to go when the person is
20 homebound, but as soon as the person can get
21 walking and get out of the house, they don't
22 really want to go in any more.

23 Now that works for many patients
24 who drive, but for the patient who is over

1 80 and has poor vision and no family and
2 can't get out of the house any more, it
3 limits what we can do.

4 On the Tufts Medicare Preferred
5 Product, for example, our physicians take
6 the money that we get and we put it back
7 into services so that our patients can stay
8 at home safely.

9 MR. MICHAEL BAILIT: What about
10 for your capitated populations that you
11 serve, what are the biggest barriers there?

12 DOCTOR BARBARA SPIVAK: I think
13 that the biggest barriers that we have are
14 that physicians honestly feel overworked and
15 underpaid particularly in an environment
16 like ours where we live in and practice in
17 Cambridge, Somerville, Watertown, Belmont,
18 Massachusetts where some of the networks
19 that we are talking about that are higher
20 paid are the people who live next door to
21 our own doctors and the nurses.

22 And we have patients I think who
23 are not invested in working with us. It is
24 very hard to get to be held accountable to

1 getting a diabetic hemoglobin A1C down when
2 they are smoking and overweight and not
3 exercising.

4 There are financial implications
5 for patients with high deductibles who need
6 tests who don't want to do them.

7 I think people have heard me talk
8 about this a hundred times. Charging the
9 patient \$250.00 co-pay for a colonoscopy
10 does not encourage that patient to get that
11 colonoscopy.

12 DOCTOR DONALD GOLDMANN: You are
13 hearing something really important here.

14 I don't know how many people come
15 to this hearing because you are patients,
16 you are here because you are patients -- are
17 there a lot of those.

18 (No affirmative response from the Audience.)

19 DOCTOR DONALD GOLDMANN: But we
20 are not -- what you are hearing is you are
21 hearing a change in the emphasis of the
22 discussion even though you are asking
23 questions about payment and network, what
24 you heard especially from Barbara just then

1 but also from others is the story of a
2 typical patient, a specific patient and you
3 will notice she didn't use the word doctor,
4 doctor, doctor. She talked about nurses and
5 people who go in the home and other supports
6 and pharmacists and she talked about the
7 patient and what their trajectory is through
8 that system.

9 She did talk a little bit about
10 doctors working too hard but basically it
11 was the story of the patient and I think you
12 can even design the policy, the payment
13 system for quality and cost from a
14 theoretical school of public health way or
15 you can listen to some of these stories and
16 figure out what would have been the lowest
17 cost, most efficient, most reliable path
18 that that patient could have followed to not
19 get back into the hospital or into the
20 Emergency Department.

21 We have actually been telling
22 stories of some patients who come to the ED
23 and it turns out that what they are telling
24 us is not a lot to do with the primary care

1 doctor or any of that. It is I didn't have
2 transportation. I was 80 years old and
3 nobody could drive me. I didn't have the
4 care.

5 Until you start really
6 understanding the stories, you can't figure
7 out the system that will address them in the
8 most lean way.

9 The other thing you mentioned was
10 the coloscopy and the nurse going into the
11 unit. There is disruption here.

12 I said in my testimony that we
13 don't pay enough attention to train people
14 in the community who are not nurse
15 practitioners or doctors who can do those
16 services. Simply with colonoscopy, the
17 disruption there is that my G.I. guy who I
18 love above all of the people in the world
19 who does my colonoscopy -- I would actually
20 rather have it done by a nurse who is
21 properly trained can probably do it for the
22 half price with him standing by.

23 I can tell you more about my
24 shoulder which can tell you more about the

1 health care system in Massachusetts than all
2 of the discussion about policy and payment
3 we have had but I won't because we don't
4 have the time.

5 MR. MICHAEL BAILIT: I have one
6 last question to ask of you.

7 In Steve Schoenbaum's earlier
8 presentation he spent sometime talking about
9 primary care in the medical home and this
10 topic has not come up in our discussion
11 today.

12 So I would be interested in asking
13 you as a group -- you can raise your hand if
14 you are interested in the topic -- to what
15 extent is primary care clinician supply --
16 primary care clinician supply and a lack of
17 medical homeness an issue that influences
18 health care costs?

19 DOCTOR JACK DUTZAR: I was
20 actually anxious to respond previously.

21 We have also built disease
22 management and other systems to care for our
23 patients and I think it has had a positive
24 impact as the others describe.

1 One of the things we have been
2 looking at is emergency room utilization and
3 we have actually done some correlations with
4 the emergency rooms around various of our
5 practices that are either over subscribed or
6 for want of a better term normally
7 subscribed. Primary care physicians with a
8 normal population versus people that are
9 just varied and overpopulation and the
10 correlation is very strong with excessive
11 E.R. utilization.

12 So one of the things that we would
13 say has been a major challenge for us is
14 building our primarily care base.

15 We believe that we could grow
16 dramatically and successfully if we have
17 access to more high quality primary care
18 physicians and that we could lower our costs
19 dramatically associated with both the more
20 comprehensive ongoing care of chronic
21 disease but also in terms of things like
22 avoidance of unnecessary and inappropriate
23 hospital utilization.

24 We are also just if I can backtrack

1 on an answer, undergoing a major lean
2 transformation and the commitment and the
3 investment of that is enormous. We are
4 doing it in concert with or in commitment of
5 developing the patient centered medical home
6 that is built with the focus on the patient
7 and the elimination of waste for the patient
8 as well as for the system itself.

9 These are all things that we can
10 demonstrate in at least one of our major
11 facilities but it is a long and very
12 challenging and difficult process.

13 If we have a single overriding
14 challenge, it is to get the kind of
15 physicians and the primary care that we need
16 to achieve our goals.

17 MR. MICHAEL BAILIT: Okay.
18 Thanks. Let me --

19 DOCTOR BARBARA SPIVAK: -- I
20 think in the primary care, I can't speak to
21 the primary care access in the state but I
22 do think that we need to work very hard to
23 make it that our primary care doctors are
24 actually doing real medical work and not the

1 kinds of paper work that is required of them
2 today, and we have to redesign the system so
3 that the amount of time a primary care
4 doctor spends on paper work is not 20 to 30
5 percent of their day but 2 percent of their
6 day and that ancillary people are doing it
7 and doing it well and I think that the
8 system has to realize that primary care
9 doctors are in short supply, the stream
10 coming from medical schools is not going
11 into primary care, and the piece that makes
12 primary care valuable is that you have the
13 same person talking to the patient over the
14 course of years, not moving from one
15 practice to another every couple of years,
16 and we have to build a practice style that
17 encourages consistency but really allows a
18 doctor to take care of patients.

19 MR. JAMES ROOSEVELT, JR.:

20 Michael, I just have to add to that -- there
21 is a cure for the primary care doctor
22 shortage and so in terms of existing primary
23 care doctors having primarily care doctors
24 doing what they should be doing both

1 clinically and administratively is
2 important. But in terms of future primary
3 care doctors, when we had an extreme nursing
4 shortage in this country, we doubled the pay
5 of nurses. We may have some misallocation
6 now but we no longer have an extreme nursing
7 shortage.

8 Tufts Medicare Preferred Primary
9 Care doctors under the global payment system
10 are better than 300 percent of what they
11 would get paid for traditional fee for
12 service Medicare. That makes it worthwhile
13 for them to do the right thing.

14 I think if we go system wide with
15 that, I think you will see a difference in
16 what students coming out of medical school
17 choose to do.

18 MR. MICHAEL BAILIT: So let me
19 wrap things up. You have been a great
20 panel, very forthcoming.

21 Some of the things that I picked up
22 first there seemed to be broad agreement
23 about the ills of our current market
24 dynamics and that is driving both increased

1 prices and also increased costs in the
2 system.

3 And there is some, I think, general
4 agreement that government has some role to
5 play in providing some protection against
6 variation that has occurred in the
7 marketplace. There is an interest among at
8 least some of you, a strong interest in
9 broader use of global payments but not
10 uniform, and in conjunction with that better
11 coordination and integration of the delivery
12 systems.

13 What I also heard is that achieving
14 some improvements aren't simply going to
15 require effective leadership. That to some
16 degree the only ways organizations get
17 better is if the leaders drive that
18 improvement in performance.

19 And the last message that I take
20 away is that a number of you feel that we
21 have got some examples in place within the
22 Commonwealth today of processes and
23 arrangements that seem to be working to some
24 degree, and that our goal of achieving a

1 more effective and efficient health care
2 delivery system is something that is
3 achievable.

4 So with that, again, I want to
5 thank all of you for your time.

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8
9 (Whereupon at 12:29 p.m., the
10 lunch recess was taken.)
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C E R T I F I C A T E

COMMONWEALTH OF MASSACHUSETTS

Norfolk, ss.

I, Maureen Nashawaty, a Registered Professional Reporter and Notary Public in and for the Commonwealth of Massachusetts, do hereby certify that the foregoing transcript taken on Thursday, March 18, 2010, is true and accurate to the best of my knowledge, skill and ability.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 11th day of April, 2010.

Maureen R. Nashawaty
Registered Professional Reporter

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Massachusetts Health Care Cost Trends Final Report

Appendix C.5d

Health Care Cost Trends Public Hearings

Transcript for Afternoon Session Thursday, March 18, 2010

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1 **COMMONWEALTH OF MASSACHUSETTS**
2 **DIVISION OF HEALTH CARE FINANCE AND POLICY**

3 **ANNUAL PUBLIC HEARING UNDER**
4 **M.G.L. c.118G, SECTION 6 1/2**
5 **HEALTH CARE PROVIDER AND PAYER COSTS**
6 **AND COST TRENDS**

7
8 **PANEL:**

9 David Morales, Commissioner, Department of Health
10 Care Finance and Policy
11 Lois Johnson, Office of the Attorney General

12 **HELD AT:**

13 University Club, 11th Floor
14 Joseph P. Healey Library
15 University of Massachusetts, Boston
16 100 Morrissey Boulevard
17 Boston, Massachusetts 02125
18 On Thursday, March 18, 2010

19 **Afternoon Session Commencing at 1:00 p.m.**

20
21
22 **COPLEY COURT REPORTING**
23 **The Mercantile Building**
24 **71 Commercial Street, Suite 700**
 Boston, Massachusetts 02109
 (617) 423-5841

I N D E X**Expert Witness: Understanding Cost Drivers in the Health Care System**

Paul Ginsburg, Ph.D., President, Center for Studying Health System Change - **Page 6**

Moderator: Stuart Altman, Ph.D., Sol C Chaikin Professor of National Health Policy, The Heller School for Social Policy and Management, Brandeis University - **Page 3**

Panel: Factors Contributing to Health Care Costs

1) Dianne Anderson, President and Chief Executive Officer, Lawrence General Hospital - **Page 50**

2) Andrew Dreyfus, Executive Vice President of Health Care Service, Blue Cross Blue Shield of Massachusetts - **Page 56**

3) Mark Gaunya, President, Massachusetts Association of Health Underwriters - **Page 61**

4) Thomas P. Glynn, Ph.D., Chief Operating Officer, Partners Healthcare - **Page 67**

5) Nancy Kane, Professor of Management, Associate Dean for Educational Programs, Department of Health Policy and Management, Harvard School of Public Health, and Member of the Medicare Payment Advisory Commission - **Page 86**

6) Dale Lodge, President and Chief Executive Officer, Winchester Hospital - **Page 74**

7) Julie Pinkham, R.N., Executive Director, Massachusetts Nurses Association - **Page 80**

Moderator: Nancy Turnbull, Senior Lecturer on Health Policy and Associate Dean for Educational Programs, Harvard School of Public Health - **Page 47**

1 **PROCEEDINGS**

2 COMMISSIONER MORALES: Thank you again
3 for coming. I hoped you enjoyed lunch. We've had
4 a really, really good and robust discussion this
5 morning, and I expect this afternoon's will also
6 be robust. I'm looking forward to it. But now
7 it's really an honor and pleasure to introduce
8 Professor Stuart Altman who is going to head up
9 our next presentation. Professor.

10 **MODERATOR ALTMAN:** Thank you. Well, I
11 have a real honor today to introduce my good
12 friend Paul Ginsburg. And I have a great
13 opportunity because after he makes his
14 presentations, I can sort of either feed him or
15 push him so that he says everything to reinforce
16 what I'm going to say tomorrow.

17 (Stenographer interrupts.)

18 MODERATOR ALTMAN: I'm sorry, we have to
19 pledge allegiance.

20 (Speakers Sworn.)

21 MODERATOR ALTMAN: Well, in a way, I
22 mean, I'm the most conflicted person you're going
23 to have, so I'm purely objective. I sit on the
24 Tufts Health Board. I'm on the board of several

1 insurance companies outside of Massachusetts. I
2 used to be on the Beth Israel board. But most
3 importantly, I'm falling apart, and I'm a patient.

4 So other than that, I'm purely
5 objective. So with that said, I think I can be
6 pretty objective. So with that said, again, let
7 me say how really pleased I am to moderate. I
8 just want to -- I don't know if all of you know
9 this, but I think if I was to single out one
10 person over the last decade who has done more to
11 educate us on what is going on in this country,
12 it would be Paul.

13 I mean, I can say that. I wish it was
14 me, but it is Paul because of what he's done in
15 his capacity as the President of the Center for
16 Studying Health System Change. Paul's
17 organization under his leadership, I've gone
18 around the country, including here in
19 Massachusetts, trying to understand the
20 underlying forces that are generating our health
21 care system here, in California and in many other
22 markets around the country.

23 And he publishes often, and he is as
24 objective and balanced because he generally

1 agrees with me, I say that, as anybody that I
2 know. We are very fortunate that he has agreed
3 in his very busy schedule to come and join us
4 here in Massachusetts.

5 Paul is not totally unknown to us. He
6 graduated and has a Ph.D. in economics from
7 Harvard, part of that core of really first-rate
8 economists that were trained in the late 1960's,
9 early 1970's. Paul went on from that, taught for
10 awhile at Duke and Michigan State, but gained his
11 real expertise working in Washington.

12 He was with the Congressional Budget
13 Office in a senior capacity and then served as
14 the director of the organization that was
15 responsible for advising Congress and the
16 Administration on the establishment and the
17 operations of the physician payment system.

18 I was on the hospital side. The two of
19 us worked very closely together. Many of you
20 know the organization today as MedPAC, but -- in
21 the eighties, we were two separate organizations.

22 Then I think Paul, for awhile, you
23 actually went on into the transition into MedPAC,
24 right?

1 SPEAKER GINSBURG: No, I left.

2 MODERATOR ALTMAN: You left. Both of us
3 left, right. So anyway, the important thing here
4 is that Paul has been a key player, understander,
5 analyst of our health care system for almost 40
6 years. So it is a great pleasure for me to
7 introduce Paul and let him give you the benefit of
8 what he has learned over these four decades.
9 Thank you.

10 **SPEAKER GINSBURG:** Thanks. It's always a
11 pleasure to be introduced by someone who really
12 nose you. You did a great job, Stuart. I don't
13 know if I can turn this around.

14 Anyway, as Stuart mentioned, one of the
15 things I do in my job is periodically visit
16 twelve randomly-selected metropolitan areas, same
17 each time, to find out what's going on in the
18 delivery, financing organization of health care.
19 And Boston has been one of them from the
20 beginning which was 1996.

21 Actually, I was here last week and met
22 some of you because my team was doing it's
23 seventh round of site visits in Boston. So to
24 begin with, you are blessed in Massachusetts by

1 having some terrific policy analysts in all
2 areas. And one of the results I think is that
3 you have some very valuable data that the
4 Division of Health Care Finance and Policy and
5 the Attorney General has produced.

6 It's richer than national data. It
7 shows that price paid to providers is a key
8 factor in the recent trend in spending here, butt
9 hat utilization contributes as well. And it
10 shows the large variation in prices across
11 providers which is something that it's rare to
12 have data that can do that, and it appears to
13 reflect in part at least the market leverage of
14 different providers.

15 So let me start at the beginning in
16 saying what drives provider prices? And
17 basically, there are two things. There's a
18 demand side and a supply side. Now, on the
19 demand side, I would summarize it as the absence
20 of demand side restraints, the absence of the
21 restraints that we have in much of the rest of
22 the economy because this is health care. And we
23 use third-party payment extensively.

24 So those who need the care are the

1 patients, you know, tend not to have much
2 constraining them as far as what they would like.
3 We see all over the country, and I suspect is the
4 case in Massachusetts too, that purchasers who
5 were employers and some individuals demand
6 insurance products with broad choice of
7 providers.

8 They won't tolerate products that omit
9 some of the notable hospitals in a community.
10 When insurers have offered narrower networks,
11 they don't find a lot of interest. Some of them
12 are viable enough to be continued, but none of
13 them draw a lot of enrollees.

14 In every community, there are must-have
15 providers, hospitals and sometimes large medical
16 groups that if they are not in the network, you
17 know, consumers look at that and say, *What a*
18 *cruddy network. I'm not going to buy that*
19 *product.*

20 So this, as you can imagine, undermines
21 insurers' ability to negotiate prices effectively
22 with providers if all of your customers want to
23 make sure that those providers are in their
24 network.

1 Also what I find is that the benefit
2 structures in insurance provide few patient
3 incentives to choose low-priced providers. For
4 example, this little use of tiering for hospital
5 or physician services the way there is for
6 prescription drugs, and people now are used to
7 prescription drug tiering where you have generics
8 where you pay the least, and then you have
9 preferred brand names. And then you have other
10 brand names, and there's a difference. People
11 accept that, but very little use of that for
12 hospital/physician services.

13 Here in Massachusetts, the General
14 Insurance Commission has been a pioneer in this
15 approach. I can't say that there have been a lot
16 that have followed what it's pioneered. And on
17 our visit last week, we heard of what seems to me
18 to be a promising initiative by Massachusetts
19 Blue Cross Blue Shield to, in a sense, have
20 significant difference in the hospital deductible
21 for their preferred versus their other hospitals.

22 Now, supply side issues are important
23 also in driving prices. The degree of excess
24 capacity in a market is certainly important. I

1 recently published a study based on interviews in
2 California which a number of you I think saw in
3 Health Affairs about two or three weeks ago.

4 And in California, you had a situation
5 of over a decade going from a situation of very
6 extensive excess capacity for both hospitals and
7 physicians to a situation of very tight capacity.
8 And that really showed up in the leverage that
9 providers have to gain higher prices.

10 Obviously, the degree of provider
11 consolidation is a factor. And also, something
12 that is a recent, rapidly-developing trend
13 nationwide is the extent to which hospitals are
14 employing or aligning with physicians in
15 different ways so that hospitals can negotiate
16 the payment rates for the physicians, at least
17 that they employ.

18 Because what we find is that physicians
19 in small practices are the one part of the
20 provider community that has very little leverage
21 with providers. In many areas, their payment
22 rates are no higher than Medicare payment rates.
23 However, if you have a hospital negotiating
24 physician payment rates, they can be much higher.

1 Now, I mentioned that there is a recent
2 national trend of growing provider leverage. I
3 think trends on the supply side factors are
4 behind this. I mentioned before, the Greater
5 Hospital Employment of Physicians, consolidation
6 has increased. Capacity is probably
7 market-by-market. It's increased in some areas,
8 not in others which have experienced building
9 booms.

10 And if we distinguish between having
11 leverage and using leverage, this is where the
12 payment rates from the public payers, Medicare
13 and Medicaid, come in. Because you could have a
14 situation where the hospital could have pushed
15 for a higher rate; but it had a goal for its
16 margin, and that's what it was.

17 Then it experiences Medicaid rate cuts,
18 and where can it turn? It can ask the private
19 insurers to pay more. It can't get more from
20 Medicaid. It can't get more from Medicare.

21 MedPAC, that's the Medicare Payment
22 Advisory Commission which is what Stuart was
23 referring to with the merger of the two
24 commissions that we led. They came back with an

1 analysis of Medicare margins. And in fact,
2 whereas this was in MedPAC reports in early 2009,
3 looking at my e-mail, it just came out, another
4 version of that, in Health Affairs Today.

5 Basically, the bottom line is that the
6 fixed payment rates that Medicare has are not
7 constraining costs at strong hospitals, that they
8 basically find that hospitals that are very
9 powerful are in a position to lose money on
10 Medicare because their costs are too high and
11 just make it up in their charges to private
12 insurers.

13 Now, how do we address rising prices?
14 And I want to point out that, you know, there are
15 market and regulatory approaches. And you know,
16 my sense of the history of health policy in the
17 last few decades in the United States is vigorous
18 arguments about whether the market is going to
19 work or whether it won't work, and we should
20 regulate instead.

21 And my sense is that we've come out of
22 that argument with a comfortable solution
23 temporarily of doing neither. I don't think we
24 push market forces or regulation very strong in

1 this country. And the point I want to make when
2 it comes to provider payments is that these
3 approaches are not mutually exclusive.

4 They're actually very closely related
5 and tied at the hip in ways I will sketch out.
6 In fact, you know, I think if you incorporate
7 market forces into regulation, it works better.
8 You won't have the degree of conflicts between
9 consumers saying, *Why can't I have this*, when
10 they don't have to make any choices as far as is
11 it worth their money to do that?

12 So what does the market approach look
13 like? I would say the market approach to buying
14 health care in the United States is different
15 types of insurance benefits structures, benefits
16 structures that include incentives to choose less
17 expensive providers over others.

18 So an example would be if the benefit
19 structure varies the hospital copay or the
20 hospital deductible according to which provider
21 is chosen. And the ultimate design, and I don't
22 expect insurers to go this far, at least in the
23 near term, is what economists call reference
24 pricing.

1 Reference pricing really just means you
2 identify who is the high-quality, low-cost
3 provider. And then your benefits structure says
4 if you want to go to a more expensive provider,
5 you pay the difference.

6 Now, such benefit structures, as I
7 mentioned, are pretty rare. Think about
8 consumer-driven or consumer-directed health care,
9 which in some parts of the country are fairly
10 popular. My site visit suggests not so in
11 Massachusetts. But you know, the irony is that
12 CDHP designs have very little in the way of
13 incentives to choose lower cost providers despite
14 all the rhetoric.

15 And it's just some concrete things,
16 because if someone has a policy with a \$2,000
17 deductible and they need to be hospitalized,
18 well, that deductible will be exceeded almost
19 automatically no matter where they go. And the
20 result will be that they pay the same no matter
21 what hospital they go to. So they don't have
22 incentives.

23 You know, there are some incentives so
24 that if someone is told they need an MRI, they

1 can probably save some money with a large
2 deductible if they go to the freestanding imaging
3 center instead of going to the hospital
4 outpatient department because they tend to have
5 lower prices.

6 For one thing, the tax treatments of
7 health insurance blunts incentives for such
8 benefit design in the sense, you know, if the tax
9 system is subsidizing your health insurance,
10 which it does for everyone who gets health
11 insurance through employment or through their own
12 businesses, you know, why should we take this
13 extra hassle when we can do that?

14 And finally, tiered networks are a type
15 of a benefit structure, but they have been
16 limited by data to do a good job in classifying
17 providers into a preferred or not preferred
18 network and by hospital resistance. And there
19 are lots of anecdotes throughout the country of
20 the most important hospitals saying we will be in
21 the preferred tier, or we will not be in your
22 network.

23 Now, I want to talk about the role of
24 transparency in, price transparency in particular

1 in market approaches. And the point I want to
2 make is that without the right benefit structure,
3 without the right price information that's
4 meaningful to the consumer, price transparency
5 can actually be harmful. It's unlikely to do any
6 good.

7 And under the situation of universal
8 insurance coverage which Massachusetts, of
9 course, is very, very close to, I would say the
10 insurer is the ideal data source for consumers
11 because the insurer is in a position to focus on
12 what is the difference in what it will cost you,
13 the enrollee, with our plan by going to different
14 providers?

15 So that's the information patients
16 should want, the information patients could do
17 something with. But it's only relevant in plans
18 that choose the low-cost providers. You know,
19 there's some concern that in plans where you
20 don't have such incentives where it will cost you
21 the same to go anywhere, why not go to the
22 highest priced provider? You know, maybe they're
23 better. So it is an example where a type of
24 transparency potentially can do harm.

1 Now, if the government is to post the
2 prices that have been negotiated between insurers
3 and providers, the impact of that is
4 unpredictable. And there are two possibilities.
5 One, which I have seen in Massachusetts in the
6 years that I've been studying with, is that
7 transparency can constrain dominant providers
8 through public pressure, in a sense just the
9 criticism and the potential avenues for
10 policymakers to punish providers who they think
11 their prices are high. This certainly might be
12 constraining it.

13 But there are also lots of situations
14 where when competitors know each other's prices,
15 that can lead to higher prices. And this has
16 been documented extensively in other industries
17 that where you have concentration, you know, a
18 small number of sellers, when you have price
19 transparency, prices go up.

20 There's a fascinating study in Denmark
21 of where the government was concerned about Ready
22 Mix concrete prices, and it posted those prices
23 on the Web; and the prices immediately went up.

24 And here's why. It's because if you can

1 cut your pricing secrets, you might get business
2 away from your competitors. But if all of your
3 competitors will know it instantly, you won't get
4 business away from them. They will match it. So
5 you won't do it in the first place.

6 So price transparency can be dangerous
7 if not used properly. And I'm saying that the
8 key thing for the potential upside of
9 transparency is patients, consumers making
10 decisions where the price to them is going to
11 vary depending on where they go.

12 Now, let me talk about the regulatory
13 approach, and this would be rate setting
14 applicable to private payers. This does address
15 the provider leverage issue. And also, it offers
16 the potential to lead in the reform of provider
17 payment methods. So in a sense, it can set
18 methods that all payers can use.

19 And also, when I mentioned the combining
20 of regulatory market, there still would be an
21 opportunity within this regulatory approach for
22 patient incentives to address the remaining
23 provider price differences. In an all payer rate
24 setting system, say for hospital care, hospitals

1 will not all have the same regulated prices.

2 There will be differences.

3 If consumers have incentives to favor
4 the lower-priced hospitals, that can actually
5 amplify the results of the regulation, perhaps
6 make it easier to pull off.

7 Now, provider rate setting is quite
8 challenging to do well. For one thing, there's a
9 high degree of sophistication needed. For
10 example, current contracting between health plans
11 and providers can be very subtle.

12 There are many examples that I've run
13 into where a physician group will negotiate a
14 fee-for-service agreement with an insurer but
15 bring data to the table saying, you know, look,
16 if you look at the patients who go to me, their
17 use of the emergency room is lower than the norm.
18 In fact, their overall utilization is lower, so
19 give me higher rates. So there's a lot of
20 complexity in arrangements that a rate setting
21 initiative needs to understand.

22 The governance structure of rate setting
23 is critical. You know, Maryland, which has the
24 one remaining significant process to set hospital

1 rates, is done by an independent commission. And
2 the independence of that commission in my view is
3 a key factor in its long-term success.

4 I think the final thing I want to say is
5 that you're unlikely to achieve large short-term
6 gains in an industry such as in Massachusetts
7 with very low operating margins.

8 Now, provider payment reform is very
9 important because service volume is a key
10 component of spending trends. And there's a need
11 for broader payment units covering multiple
12 providers. Basically, we need more meaningful
13 units to price.

14 And I think this is the key to the
15 success of both market and regulatory approaches.
16 They need a better payment unit. And
17 Massachusetts clearly is on the path towards
18 developing global payments to address this.

19 And there can be a range of large and
20 small steps to reform the provider payment
21 methods. We're seeing new versions of
22 capitation. Here in Massachusetts, there's the
23 alternative quality contract from Blue Cross Blue
24 Shield, a lot of discussion at the federal level

1 about accountable care organizations.

2 There are opportunities to have per
3 episode payment for selected episodes. Payment
4 to medical homes, you know, a lot of people focus
5 on the delivery system side of medical homes; but
6 there's a payment side which I would call partial
7 capitation. For patients with chronic disease,
8 there's a capitated payment to the medical home.

9 Simple things like incorporating post
10 acute care into hospital payment so that the
11 hospital's responsible for rehab; and even down
12 to the nitty-gritty level of incentives to reduce
13 hospital admissions.

14 Maybe I better to skip this. Let me
15 turn to my paper. Sorry about that.

16 (Pause.)

17 SPEAKER GINSBURG: I mentioned I was in
18 Boston last week. And some of what I came away
19 with on the interviews was that, I would say the
20 theme of our visit in our upcoming report is going
21 to be controlling costs. Everybody was talking
22 about that. And Boston providers are anticipating
23 greater accountability for spending as well as for
24 quality.

1 And their efforts to increase efficiency
2 are already underway. And we heard a lot of
3 encouraging reports about the alternative quality
4 contracts spurring changes in providers.

5 Who's going to take the lead in provider
6 payment reform? And there are a number of
7 possibilities. Certainly, we're seeing around
8 the country and in Massachusetts significant
9 private payer experimentation with different
10 methods. There is the potential, and it's
11 expected under health care reform, if in fact it
12 should pass at the federal level, then Medicare
13 will do substantial reform in its methods, and it
14 will be leading the entire system.

15 Then there's the potential for states to
16 develop and prescribe payment methods as
17 Massachusetts is thinking about and using a
18 Medicare waiver to bring Medicare into their
19 system. And finally, should there be an
20 all-payer rate setting system, that could lead
21 payment reform.

22 So in conclusion, a great deal is at
23 stake in slowing spending trends, and we should
24 be focusing on both price and quantity or

1 utilization because whereas in recent years,
2 price has been more of a factor, I don't have
3 confidence that that will continue. And the
4 volume of health services is, has been our
5 long-term factor and I'm sure will continue to be
6 as well.

7 And I believe that reforming provider
8 payment methods is the key to a substantial
9 bending of the curve. And we want to get you to
10 think in terms of ways to combine market and
11 regulatory elements rather than just argue over
12 which one we should do and the other one is
13 awful. Thanks.

14 MODERATOR ALTMAN: Thank you very much.
15 So let me press you a little bit, Paul, on a
16 couple of things to see, A., if I understand it;
17 and B., if this could help.

18 First, let me simplify for a minute and
19 differentiate between the possible argument that
20 said what we heard at the last panel, and I think
21 you said it as well, is one of the leading causes
22 of increased spending, increased costs have been
23 price increases over the last decade and that
24 most of those price increases have come from the

1 increased power of providers, particularly
2 hospital systems, the consolidation and changing
3 market structure and the like.

4 So we face now two distinct options,
5 which I think you've done a good job of trying to
6 bring them together. But let me keep them
7 separate for a minute. One is to essentially try
8 to force the market to work better in two ways.

9 One, and let me see if I got this right,
10 and please correct me if I don't. One is to
11 reduce the market power of the providers possibly
12 by making them smaller and breaking up their
13 power base. And two is by making information
14 available to the -- and in doing that, you will
15 really increase the power of the payers.

16 And two, is to bring in, and these
17 aren't inconsistent, the consumer more by more
18 transparency of information on higher, but you've
19 cautioned us in a lot of ways that that really
20 has a downside. So that's one side. And on the
21 other side is provider rate setting through some
22 form of regulatory structure.

23 But I want to focus now on changing the
24 payment system independent of changing the

1 delivery system. So first of all, let me ask you
2 if I got that part right?

3 SPEAKER GINSBURG: Yes. I would say --
4 well, you were summarizing the morning panel, and
5 I wasn't here.

6 MODERATOR ALTMAN: I'm trying to put it
7 in your context as well.

8 SPEAKER GINSBURG: Sure. The key thing,
9 as I was saying, that transparency for consumers
10 isn't worth anything until they have incentives.

11 MODERATOR ALTMAN: All right. Now,
12 here's the issue, and it's the issue that I have,
13 and it's the issue I think you've brought up, and
14 I want to reinforce it. If we simply broke up the
15 power base or if we did transparency, or if we did
16 provider rate setting on the existing delivery
17 system, how would you feel about that?

18 SPEAKER GINSBURG: I think that would be
19 very limited as to what it can accomplish because
20 our ultimate long-term problem is that we use
21 health services very inefficiently in a sense in
22 this country when we have a new technology, we
23 tend to overuse it.

24 We use it -- for example, there was a

1 study that, I think a number of studies have come
2 out that talked about aggressive treatments of
3 cardiovascular conditions. Someone who has high
4 cholesterol who has some bad scores but is
5 perfectly, feels perfectly healthy, intervention
6 with angioplasty and stents doesn't improve their
7 life. It doesn't have positive outcomes.

8 My sense is that we do those things more
9 than in other systems. And I think that's one of
10 the real challenges. Basically, it's just
11 overuse of health services or use of a lot of
12 low-value health services and our fee-for-service
13 payment system where the delivery system as the
14 incentives to drive volume works against that.
15 So we really do need a much profound change in
16 the way we pay providers.

17 MODERATOR ALTMAN: And that's it. Let me
18 build on that. I think you've made that point,
19 but let me home it in. What I heard you say, and
20 obviously what we talked about this morning, is
21 the idea that we need to change the payment
22 system. And you call it a broader units of
23 payment. Whether we call them capitation, global
24 payments, bundled payments, payments for value,

1 they come under different names, and they have
2 slightly different meanings.

3 But at the end, is it the payment system
4 that's important; or is it that the payment
5 system will drive delivery system change?

6 SPEAKER GINSBURG: Oh, yes. The reason
7 we're focusing on a payment system is because we
8 expect the delivery system will respond very
9 vigorously to the different incentives in
10 different payment systems.

11 MODERATOR ALTMAN: So now I get to the
12 third piece. Is bigness necessarily bad, or is
13 smallness in a delivery system necessarily good?

14 SPEAKER GINSBURG: No, I don't think so.
15 I'm not convinced that we could accomplish that
16 much simply by breaking up large delivery systems
17 because largeness is just one of the factors
18 behind leverage.

19 And often largeness can lead to upside
20 as far as efficiency or even quality in the sense
21 you take an ordinary community hospital and link
22 it up with a leading hospital, and sometimes you
23 can improve the care at the community hospital.
24 It means that that community hospital has more

1 leverage, but I'm not sure that the best approach
2 would be to break that up.

3 MODERATOR ALTMAN: Yes, so that is very
4 important. But you also made in your article, and
5 I commend everyone to read the latest Health
6 Affairs that came out before the Web one, where
7 Paul had an article about what's going on in
8 California.

9 And I think your point was that
10 accountable care plans that integrate care but
11 just do that, that give market power, but you
12 have nothing on its other side, can lead to
13 higher costs. But on the other hand, and I don't
14 want to put words in your mouth, can we really
15 have serious integrated care without bringing all
16 the pieces together? And I think that's what you
17 were --

18 SPEAKER GINSBURG: Yeah. Actually, my
19 sense is I look at some of the really famous
20 integrated systems that everyone points to
21 providing great care, efficient care. Often a
22 dirty little secret is they have very high payment
23 rates.

24 Why? Not because they're greedy, but

1 because our financing system is so driven towards
2 extensive use of services that if an integrated
3 system uses services judiciously, they lose out.
4 They lose big. And you know, that's why when
5 faced with low Medicare rates, they have to have
6 high private payer rates.

7 So basically with a fee-for-service
8 payment system where many of the prices are
9 distorted, so that we pay physicians much more
10 for the things they do, and particularly for the
11 facilities that they use to provide the services,
12 that actually as long as we have a payment system
13 like that, we can't expect much real integration
14 of delivery.

15 We've known for a long time to
16 effectively treat a congestive heart failure
17 patient which means keeping them from coming back
18 into the hospital by better outpatient care,
19 large systems that have tried to do that lose
20 money because they're not rewarded for the better
21 outcomes, for the lower costs. They just have
22 fewer services to bill. If that patient doesn't
23 come back into the hospital, there's no admission
24 to bill for.

1 MODERATOR ALTMAN: So as you look at
2 Massachusetts, its structure, its strengths and
3 its weaknesses, let me put you on the spot, what
4 would you advise us to do?

5 SPEAKER GINSBURG: Actually, I've got a
6 problem with that because in my organization, I
7 have never made a policy recommendation. So if
8 you could rephrase your question?

9 MODERATOR ALTMAN: All right. You'll
10 leave it to me. That's fine, but -- go ahead.
11 Rephrase your question. Well, there's a similar
12 system out -- no, I can't. There's no way I can
13 rephrase that question and get the answer I want.

14 SPEAKER GINSBURG: Yeah, I mean, you can
15 ask me about for different options which ones I
16 think might have a substantial impact.

17 MODERATOR ALTMAN: Thank you.

18 SPEAKER GINSBURG: But not which ones
19 should Massachusetts do.

20 MODERATOR ALTMAN: Okay. So that's the
21 question. Of the different options, Which one
22 seems to be the preferred option?

23 SPEAKER GINSBURG: Well, what I would say
24 is that as you are getting to -- reforming the

1 payment system is the first step because I don't
2 think any of these options, getting more
3 engagement by consumers, a market approach or a
4 regulatory approach when you're just regulating
5 the prices is going to accomplish that much until
6 you have better units of payments. And I think
7 ultimately it's going to have to be something
8 capitation-like or global-like.

9 I think that bundled episodes can play a
10 useful role if we're selective in identifying the
11 episodes that we want to bundle, and the ones we
12 want to bundle are the ones that aren't
13 discretionary, but where there's a lot of
14 variation in costs.

15 So in a sense, think of hips. Hip
16 fracture, good candidate for episode-based
17 payments. Hip replacement, I'm not sure about
18 that. That's much more discretionary. So I
19 think these are the big picture payment changes.
20 There are little -- I was impressed that all of
21 the hospitals I interviewed in Boston were doing
22 something to reduce hospital re-admissions.

23 So this is something where it just came
24 up as a policy issue that, you know, Medicare has

1 toyed with, you know, paying less to hospitals
2 that have a lot of re-admissions; or I would
3 rather them using the warranty approach of
4 Guisinger, saying go pay them somewhat more for
5 the first admission, and let them take care of
6 any re-admissions. You know, you find a lot of
7 response, a lot of hard work being done by
8 hospitals to reduce their re-admissions.

9 So anyway, I think the first thing is to
10 get a better payment system. Then I would
11 suggest doing two things, both, you know, working
12 on benefit structures that engage consumers to
13 take cost into account when they choose
14 providers, and I'd also -- if you think that
15 Massachusetts could do it as carefully and as in
16 a sophisticated manner that Maryland has been
17 doing its hospital rate setting, it ought to be
18 considered.

19 I don't know that Massachusetts did it
20 that way when it did it in the 1980's. Although,
21 I never looked at it very closely. I know that
22 some states did it pretty carelessly; and the
23 hospitals hated it, and then they got it
24 repealed. So I think those are directions to

1 look at.

2 MODERATOR ALTMAN: Let me, before I
3 finish, I would appreciate if the audience would
4 take me off the hook at some point. So if you
5 have questions, please write them down on the
6 cards so I can stop, you know, making a fool of
7 myself.

8 So with that said, let me try one more
9 time to push you in a little direction which I
10 think you had just begun to talk about. I would
11 say for myself, I'm very proud of being part of
12 this Commonwealth and the quality of the care
13 that we provide and the kind of providers and
14 payers we have.

15 And you pointed out in your testimony
16 that we have a rich data source that probably no
17 other state or very few other states have; and as
18 a matter of fact, in many respects, even better
19 than the national. The question is, Can a state,
20 can any state, but particularly this state, go
21 out on its own and sort of break with the pack,
22 break with what is going on around the country
23 and do something significant?

24 SPEAKER GINSBURG: Yes. I believe that a

1 state like Massachusetts can go out on its own,
2 and it may find itself influencing the rest of the
3 country. You know, we've had examples of
4 individual delivery systems going out on their
5 own. It's not easy, but they seem to have
6 maintained it.

7 You know, today the current popular
8 delivery system is the Geisinger system in
9 Pennsylvania. And you know, they have some
10 advantages, but they really seem to be developing
11 the type of care that the policy wants like
12 Stuart and I talk about should be the direction,
13 and they're doing it. And they're just one
14 delivery system. So in a sense, I think as
15 Massachusetts, you can do more.

16 I mean, sure Massachusetts cannot
17 influence the state of the research on the
18 effectiveness of different medical approaches,
19 but I think there's a lot of evidence that's out
20 there now that can be used a lot better than it
21 has been in providing care efficiently.

22 MODERATOR ALTMAN: Thank you very much,
23 Paul. Let me turn to some of the questions that
24 I'm receiving from the audience. And then if we

1 have time, I'll get back.

2 First of all, if all payers pay
3 providers the same rates, tiered or otherwise,
4 why not have a single payer which can get more
5 benefits from its scale?

6 SPEAKER GINSBURG: Okay. I think that
7 the difference is -- well, basically, if you --
8 you know, the single payer has advantages in being
9 able to pay less for care. Basically, an
10 all-payer rate setting accomplishes that with a
11 multi-payer environment. This actually is what
12 happens in Germany where they have multiple
13 payers, but they all negotiate together with the
14 providers.

15 I think that the payers can contribute a
16 lot in their review of claims in the wellness
17 programs that their customers asked them to
18 develop and to have -- and just because they are
19 free of political interference.

20 So I think it's a very different -- I
21 think actually an all-payer system in some ways
22 is a bit of a threat to the world's single-payer
23 advocates because it's taking one of the things
24 that single payers believe to have the potential

1 to accomplish and doing that within our
2 multi-payer system.

3 MODERATOR ALTMAN: Very good. One of the
4 important questions, you made reference to the
5 undesirability of price transparency. Do you see
6 asystemetric (phonetics) information as playing a
7 role in the rising costs of health care; and if
8 so, how can it be addressed besides price
9 transparency?

10 SPEAKER GINSBURG: Well, I think the
11 asymmetric information between patients and
12 providers? Is that what you think they meant?

13 MODERATOR ALTMAN: Pick as you feel.

14 SPEAKER GINSBURG: Okay, sure. I don't
15 think it's a situation of asymmetric information
16 because we're talking about information that
17 patients or consumers would, even if they had it,
18 wouldn't have anything to do with it.

19 In a sense, if -- you know, if their
20 plan is going to pay the same or it's going to
21 cost them the same no matter what provider they
22 go to, I don't see that that information or their
23 lack information is hurting them at all today.

24 MODERATOR ALTMAN: This is an important

1 question. It seems integration is everyone's
2 goal. But when do you expect the savings to
3 accrue from integrated systems? The existing
4 integrating systems in Massachusetts have been
5 operating for years. Why haven't they
6 demonstrated savings?

7 SPEAKER GINSBURG: That's a good
8 question, very good question. I mean, I don't
9 know that we have the information to conclude that
10 the integrated systems have not achieved savings.

11 MODERATOR ALTMAN: Now, this is an unfair
12 question to ask, but it's probably aimed more at
13 the politicians in the room. Could you speak to
14 the risks that in an election year that rate caps
15 can do to the state's health plans, hospitals and
16 consumerism?

17 SPEAKER GINSBURG: No, I won't do that.

18 MODERATOR ALTMAN: Good answer. You
19 know, one of the issues that doesn't come up, and
20 I'll give you an opportunity, how can we -- and
21 let me broaden it.

22 In some kind of a rate setting system or
23 some kind of global payments, how can we deal
24 with so-called societal goals like GME, special

1 services, trauma, et cetera and research to be
2 paid more in some form of a global payment
3 system? Is that possible?

4 SPEAKER GINSBURG: Yeah. I think that
5 that really is an issue. I mean, the ideal thing
6 would be for those societal goals is that you find
7 other ways to support them. So in a sense, an
8 example would be that Medicare has payments for
9 gradu-medical (phonetics) education.

10 You might decide that however we want
11 society to support the extra costs of
12 gradu-medical education, it should be done by
13 government because it's a social objective.
14 Because you're right, in a rate setting system,
15 you could allow the academic medical centers to
16 have higher rates; but then if you brought in a
17 market system, then you're going to have
18 consumers shunning them because of the fact that
19 they have to pay the higher rates.

20 So you know, it's not an urgent problem.
21 But the ultimate solution, and since we as a
22 country don't like to pay more taxes, is to have
23 the social activities funded by taxes. But since
24 we don't want to do that, we get left to, you

1 know, very second-best solutions of how can we
2 protect this function that we think we agree
3 should go forward but is not consistent with the
4 market?

5 MODERATOR ALTMAN: No, I want to
6 emphasize when I was on the Medicare Commission,
7 we got into a to-do about GME funding
8 independently. The then-senator from Texas went
9 on and on. And I said, Well, the day you pass
10 legitimate funding for GME first, then we can take
11 it out of the Medicare payment system. But I'm
12 waiting for you to pass it first.

13 So that's a very important -- ideally,
14 most people, and at least most economists, would
15 like to see it funded independent of the payment
16 system; what you said. But the reality is it
17 often gets short-threaded. And so it's been
18 built into our payment structure.

19 SPEAKER GINSBURG: Because the payment
20 structure doesn't really play much of a role these
21 days as far as effecting where people get their
22 care, we've been able to continue doing this
23 second-best way without many consequences. The
24 point is that if we actually did engage the market

1 anymore, we wouldn't have that luxury that we have
2 today.

3 MODERATOR ALTMAN: This is a very unfair
4 question.

5 SPEAKER GINSBURG: I don't have a problem
6 with that.

7 MODERATOR ALTMAN: Particularly for
8 people like us. To quote a statement that you
9 made in a previous article several years ago which
10 I think is a terribly -- I think it's a terrible
11 question anyway.

12 So with that said, you wrote a paper in
13 2008 about the advantages and disadvantage of
14 costing out nursing care and incorporating
15 nursing intensity waste. How would you bring
16 that into any kind of a current payment system?

17 SPEAKER GINSBURG: Okay. If I remember
18 that paper, that was really a very short one, it
19 was pretty skeptical about doing that. I don't
20 think I can remember exactly what I --

21 MODERATOR ALTMAN: That's what I said, it
22 was an unfair question.

23 SPEAKER GINSBURG: That's right.

24 MODERATOR ALTMAN: But it's a good

1 question.

2 SPEAKER GINSBURG: Right.

3 MODERATOR ALTMAN: Particularly, it's one
4 of my students, so I have to be very mindful. All
5 right. Let me get one more question in.

6 SPEAKER GINSBURG: I didn't realize
7 anyone would be reading that when I wrote it.

8 MODERATOR ALTMAN: The idea that you'd
9 remember it, that's the hard part. This was
10 again, you were not here, Massachusetts had what
11 we call Chapter 495 which deregulated the hospital
12 payment system and created a commission to monitor
13 the impact of deregulation, two years later, the
14 commission was dissolved because the commission
15 said the system was working well without
16 regulation. Please comment.

17 Really, what they're saying is, What
18 happened after that?

19 SPEAKER GINSBURG: Actually, I don't
20 remember the exact dates. But one thing I would
21 say is that during the 1990's in this country,
22 when managed care was really at its peak of power
23 and influence, we didn't need to worry about, you
24 know, hospital, regulating hospital payment rates

1 because the managed care companies had narrow
2 networks.

3 You know, they had no problem excluding
4 a prominent hospital from their networks, and
5 they had a lot of clout. I think one of the
6 reasons that some states abandoned their rate
7 setting system is they said, hey, we've got
8 managed care. And I agree with them.

9 You don't need to do that, because
10 managed care. There are a number of issues that
11 are very important under fee-for-service, like
12 self referral restrictions of physicians. It's a
13 very critical thing. Under managed care, we
14 didn't need that.

15 So in a sense, there were a lot of
16 policy areas. It's almost like we took a
17 ten-year vacation from it because we believed
18 with good reason that the type of managed care we
19 had in the 1990's was really a better way of
20 addressing the issues.

21 And then what happened is we as a
22 society decided we really don't like this. And
23 you know, so starting in the late 1990's, managed
24 care plans broadened their networks. They got

1 rid of a lot of restrictions. Use went up.
2 Capacity got tighter. And that's led to our
3 current situation.

4 So you know, the 1990's, provider price
5 was not an issue at all in private insurance. In
6 2010, it's a big issue. And a lot of that's
7 because we had developed a system to address it,
8 and then we changed our minds. And it took us
9 quite awhile to realize we have to get back to
10 some of the stuff we were talking about before
11 managed care.

12 MODERATOR ALTMAN: Before I bring this to
13 a close, I want to turn to David and ask, Do you
14 have any questions of our speaker?

15 MS. JOHNSON: From the one brief
16 follow-up. In your presentation, you mentioned
17 you've noted based on the evidence that we put
18 into the hearing that price is a factor.
19 Utilization is also a component. But you
20 indicated that price is maybe more of a factor
21 recently; but in the long term, you would expect
22 that that wouldn't be as much of a factor as
23 utilization. I wanted to ask without intervention
24 on the price in the market issues, do you think

1 price is still going to be a factor?

2 SPEAKER GINSBURG: Yeah. I think my main
3 point was that the, you know, the role of price
4 has varied depending on the role of managed care,
5 capacity. And the degree to which utilization is
6 a smaller or a larger factor during different
7 eras, I'm not talking percentage, but more just
8 the absolute value, something I have been able to
9 understand.

10 I've heard a number of comments lately
11 that the growth of imaging has stopped. I don't
12 know why. So in a sense, there's a lot of
13 variation of every few years in the utilization
14 trend where we don't really understand. So it's
15 not as if we're in a position to say, oh, it's
16 slowed down, it will remain low. I'm just saying
17 it surprised us by slowing down. It will
18 probably surprise us when it speeds up again.

19 And that, you know, long term is
20 probably responsible for more in the growth of
21 health spending beyond general inflation than the
22 price factor has; but you know, the price factors
23 are an issue at the moment. And the key thing is
24 that we shouldn't lose track of the utilization

1 or the volume side because we know that will be
2 with us long-term.

3 MODERATOR ALTMAN: First, let me thank
4 the audience.

5 COMMISSIONER MORALES: I still have one
6 more.

7 MODERATOR ALTMAN: David, I'm sorry. I
8 wasn't looking.

9 COMMISSIONER MORALES: No problem. Paul,
10 thank you so much for today. As you know, there
11 has been a lot of debate recently in the last six
12 months and recently in the last few weeks in
13 particular about how do we address the rapid and
14 escalating cost in health care here specifically
15 in Massachusetts.

16 I want to ask you not for your
17 recommendation, but what do you think is in the
18 short-term the most blunt object to use outside
19 of rate and price setting?

20 SPEAKER GINSBURG: Well, the --
21 certainly, I would expect there will be some
22 decentralized private market responses to that.
23 People will trim down their benefit structure and
24 basically get less health insurance. I think some

1 employers may shift it to employees.

2 At least in Massachusetts, you don't
3 have to worry about dropping coverage. And
4 the -- so in a sense, but what, as blunt as it
5 is, where could you get the fastest implants in
6 Massachusetts? I really don't know.

7 And I think, you know, you're dealing
8 with, you know, the insurance industry, not a
9 high-margin industry, certainly in Massachusetts.
10 Hospital industry, not a high-margin industry.
11 So in a sense, the ability to get quick cuts that
12 aren't just coming out of someone else's pocket
13 is probably pretty limited.

14 MODERATOR ALTMAN: Any other questions?
15 Okay. Let me again thank the audience for great
16 questions and particularly thank our speaker.
17 Thank you again, Paul. That was fantastic.

18 COMMISSIONER MORALES: Thank you,
19 Professor Altman. We're going to take a short
20 two-minute break to get our next panel organized.

21 (Short recess taken.)

22 COMMISSIONER MORALES: Thank you again
23 everyone for your patience and for attending
24 today's second part of our cost run hearings.

1 It's really an honor now to introduce our next
2 moderator who will introduce our next panel. And
3 remember prior to doing that, we will ask everyone
4 to present under oath. But without further ado,
5 Nancy Turnbull.

6 **MODERATOR TURNBULL:** Good afternoon,
7 everyone.

8 FROM THE FLOOR: Good afternoon.

9 **MODERATOR TURNBULL:** Thank you very much.
10 You know they say at Harvard, asleep when the
11 class starts, your fault; asleep when the class is
12 ended, my fault. I'm really happy to have been
13 invited back today to moderate this panel on cost
14 drivers.

15 A number of you have noticed that since
16 Tuesday's panel, my hair is shorter. I thought
17 if we were going to talk about some people in
18 health care getting a haircut, I should go first.
19 As an example, I thought I was going to be under
20 oath, so I was going to tell you that this is my
21 natural color; but I won't get into that. The
22 purpose of this -- oh, you do want me under oath?
23 It's still my natural color.

24 (Speakers sworn.)

1 MODERATOR TURNBULL: So if Tuesday was
2 the anatomy of the health care cost problem, today
3 I think the focus is more on the physiology of the
4 cost problem. And some people have told me, I
5 think falsely, that this particular panel is the
6 truth and reconciliation panel of the cost
7 hearing. But it's really not.

8 I'm hoping that we're going to have a
9 very interesting and lively conversation. We
10 certainly have a great panel. So I'm eager to
11 get started. There's a lot to talk about, so I'm
12 going to keep the introduction short. And you
13 have full bios of everyone in your packets.

14 Dianne Anderson is the president and CEO
15 of Lawrence General Hospital. I actually was
16 planning to stop at that point, but after
17 Tuesday's release of the AGO report and the
18 beauty of transparency, I can tell you that
19 Dianne's hospital is number 49 of 66 on Blue
20 Cross's payment.

21 Tom Glynn is the CEO of Partners
22 Healthcare. Tom's hospital is ranked up on this
23 side, and is sort of in the middle here.

24 Dale Lodge, the President and CEO of

1 Winchester Healthcare Management. Dale is also
2 in the middle of the chart. We have a good range
3 in terms of payment disparities I think to talk
4 about today.

5 Julie Pinkham is the Executive Director
6 of the Mass. Nurses Association. Mark Gaunya is
7 the President of Mass. Association of Health
8 Underwriters which represents a range of people
9 involved in employee benefits.

10 Andrew Dreyfus is the Executive Vice
11 President of Blue Cross and Blue Shield of
12 Massachusetts, the largest health insurer in the
13 state. It's my joke with Andrew, he perhaps drew
14 the short straw and is representing health plans
15 today. He is outnumbered 4 to 1 I guess among
16 providers.

17 Finally, my dear colleague, Nancy Kane,
18 who is a Professor of Management and Associate
19 Dean with the Harvard School of Public Health.
20 Nancy, as many of you know, she's a member of the
21 federal Medicare Payment Advisory Commission
22 which has been mentioned a few times today. So
23 I'm sure she'll add perspectives on many issues,
24 but particularly how some of the payment

1 challenges and market systems challenges here
2 compare to some across the country.

3 So a great group of people to talk about
4 this. We're going to use the same format we've
5 used so far. Each of the panelists is going to
6 give three to five minutes. Someone is going to
7 try to keep them within three to five minutes.
8 It's not going to be me actually, but thank you.
9 Then we'll go on to questions both from me and
10 from you as well.

11 So Dianne, do you want to start, and we
12 can go I guess just down the line would be fine,
13 so.

14 **SPEAKER ANDERSON:** Thank you. Good
15 afternoon. I'm Dianne Anderson, the President and
16 CEO of Lawrence General Hospital. I really
17 welcome this opportunity and proud to tell our
18 important story. And I really want to thank
19 Commissioner Morales, Attorney General Coakley and
20 her team for putting this panel together.

21 I'd like to say that Lawrence General
22 Hospital is the best kept secret in the Merrimack
23 Valley. We're a comprehensive community
24 hospital, about 200 beds, and we have the third

1 busiest emergency department in the state. One
2 that sees about 78,000 visits a year.

3 We have some unique features such as an
4 accredited trauma program and a nationally-known
5 family practice residency. We are a natural
6 medical home for a large population in the
7 poorest community of the state and really an
8 example of high access, high quality and low cost
9 care.

10 However, it is not sustainable long-term
11 with our current private and government payer
12 rates. Lawrence General is a disproportionate
13 share hospital that serves a largely Latino
14 population. We have the highest proportion of
15 Medicare patients of any community hospital in
16 the state, and our private payers make up only 24
17 percent of our revenue. So we don't have the
18 same market clout to negotiate the same rates as
19 all hospitals.

20 We are a case study for the Attorney
21 General's findings that insurers pay
22 substantially lower rates for hospitals like
23 Lawrence General and that the reimbursement
24 system is truly broken.

1 In fact, the rate data provided for
2 these hearings by the state's three largest
3 health plans made it crystal clear. Lawrence
4 General and other disproportionate share
5 hospitals like us are the worst paid hospitals in
6 the state.

7 From '04 to '06, Harvard Pilgrim paid
8 Lawrence General the lowest rate in the state, 69
9 out of 69. For the most recent years, Tufts paid
10 us only 69 percent of the hospital average and
11 Blue Cross about 89 percent of the average
12 medical costs. Our physicians do not fair much
13 better. For Harvard Pilgrim, they're paid in the
14 bottom 15 percent; and for Tufts, 19 percent
15 below average.

16 At the same time, Medicaid which
17 accounts for 34 percent of our gross revenue pays
18 us less than 70 percent of our cost and in the
19 past two years has cut our Medicaid outpatient
20 rates by 10 percent, cut all support for our
21 training program of our 24 residents in the
22 family practice residency program. This is a
23 program that was created to ensure primary care
24 access for Medicaid patients.

1 And even our Medicaid inpatient rates
2 are only 2.6 percent higher today than they were
3 five years ago. We've taken many steps through
4 the years to control costs and stay profitable,
5 reduce FTE's, refine contracts, vendor contracts,
6 opened up new services and automated.

7 We believe we're very nimble, but we
8 have no more low-hanging fruit in terms of
9 programs and services to cut. While we see other
10 hospitals and doctors in our area getting higher
11 rates, our low rates do not allow us to invest in
12 our physical plant, new capital or information
13 technology. As a result, our hospital buildings
14 are more than 50 years old and desperately need
15 replacement. And our information technology
16 requires significant investment.

17 We pay a premium to borrow because the
18 markets look unfavorably on our reliance on
19 government payers. It is very difficult for us
20 to compete with other hospitals that get better
21 rates for privately-insured patients. And our
22 ability to continue the comprehensive care our
23 community and patients deserve in the long-term
24 is threatened.

1 We're also the largest employer in
2 Lawrence in an area with an unemployment rate of
3 16 percent. We face the same pressures as
4 everyone else on wages and benefits, medical
5 malpractice and capital equipment. Our patients
6 require additional services such as interpreters,
7 financial counseling and dedicated bilingual
8 primary care providers.

9 Together, with Greater Lawrence Health
10 Center, we created a national model for training
11 family practice residents. We trained 102
12 physicians in the past few years and added more
13 than 20 physicians currently to Lawrence. This
14 program is in jeopardy in the future without
15 reimbursement.

16 In the recent months, the State,
17 experimenting with the new health plan,
18 CeltiCare, and its selected provider network
19 tried to redirect legal immigrants who relied on
20 us as a medical home to a hospital outside of
21 Lawrence. We needed our legislative delegation
22 and the press to help tell our story to continue
23 to provide care to our patients.

24 This flies in the face of health care

1 reform as I understand it, which is high access,
2 low cost and high quality. The CeltiCare
3 experience was a red flag to us that market clout
4 and leverage will determine network development's
5 selective contracting in the same way it does
6 overpricing.

7 Larger systems have the market power to
8 dominate and sideline excellent providers like
9 us. There is no reason why physicians with the
10 same training, credentials, experience providing
11 care at hospitals with no difference in quality
12 or outcome should be paid vastly lower prices.

13 We believe that we are a model hospital
14 to be a solution for health care reform for low
15 cost, high quality and local; but unfortunately,
16 our current private and government payer rates do
17 not recognize that fact. We are grossly
18 underpaid for our value.

19 We believe there is a critical need for
20 strong, vibrant community hospitals to provide
21 outstanding cost-effective care close to home.
22 We provide an excellent local affordable care
23 model, but only if the reimbursement playing
24 ground is made level. Thank you for this

1 opportunity.

2 **SPEAKER DREYFUS:** Good afternoon,
3 Commissioner Morales, Assistant Attorney General
4 Johnson, our distinguished moderator with the nice
5 hair and fellow panelists and guests. My name is
6 Andrew Dreyfus, Executive Vice President for
7 Health Care Services at Blue Cross and Blue Shield
8 of Massachusetts. Thank you for the opportunity
9 to make some brief remarks to frame our written
10 response to questions posed by the Division and by
11 the Office of the Attorney General.

12 Blue Cross is acutely aware that the
13 health care costs in this state are rising at a
14 rate that is not sustainable for individuals,
15 families, business or government. In the current
16 economic climate, this is especially true for
17 small business.

18 What's more, despite the high standards
19 of health care in Massachusetts, no one believes
20 that we're getting the best value for our health
21 care dollars in terms of maximizing the quality
22 and the safety of patient care.

23 As a local not-for-profit health plan,
24 employer, established member of the business

1 community, and an enthusiastic participant in
2 Massachusetts Health Care Reform, Blue Cross is
3 deeply committed to and engaged in developing
4 constructive solutions to our affordability
5 crisis.

6 Recent studies and reports produced by
7 and for the Commonwealth have confirmed that
8 rising health insurance premiums are being driven
9 almost entirely by the growth in underlying
10 medical costs. That is certainly the case at
11 Blue Cross where approximately 90 cents, 90
12 percent of the premium pays for medical services
13 we purchase on behalf of our members and the
14 remaining 10 percent pays for administration.

15 The written response we submitted for
16 this hearing explains in detail how Blue Cross
17 accounts for and allocates our costs. In
18 general, the unit costs account for approximately
19 50 percent of our annual increases in our medical
20 spending. This is a result of paying hospitals,
21 physicians and other care providers more per unit
22 of service.

23 Increased utilization of services such
24 as specialty pharmacy or lab and radiology

1 services constitute as much as 25 percent of
2 medical cost trends. And the mix of providers
3 our members use account for about 20 percent
4 including shifts in care from lower to higher
5 cost settings. All three of these factors, cost,
6 utilization and provider mix must be considered
7 in any effort to bend the trend along with
8 continuous health and quality improvement.

9 Let me first address the other part of
10 the equation, our administrative costs. The 10
11 cents of every premium dollar we spend on
12 administration includes salary and benefits,
13 other typical business expenses, technology
14 investments and a wide range of care management
15 programs aimed at improving the health of our
16 members.

17 To lower our administrative costs and
18 maximize the value of each dollar spent, we have
19 taken significant steps to run our business more
20 efficiently and effectively. We eliminated \$40
21 million of administrative costs in 2009 equal to
22 about a 4 percent reduction and have identified
23 an additional 40 million in savings in 2010 and
24 beyond.

1 This effort included reducing the size
2 of our workforce as many other employers have
3 done. While these substantial administrative
4 savings are important, they're easily overwhelmed
5 by rising medical costs. As the National
6 Association of Insurance Commissioners stated in
7 the February 23rd letter to Congress, "The single
8 most significant contributor to rising health
9 insurance premiums has clearly been the continued
10 growth of health care spending, which must be
11 addressed through payment reform, delivery system
12 changes and emphasis on prevention and consumer
13 engagement."

14 We are convinced that payment reform
15 will support high-quality care and reduce per
16 capita spending over time, and our Alternative
17 Quality Contract which we introduced last year is
18 one example of how it can be done.

19 Another opportunity that is both
20 promising and challenging is consumer or patient
21 engagement. Here the paradigm needs to change
22 from one where involvement too often means
23 benefit buy-downs and increased patient
24 cost-sharing to one of true engagement with

1 consumers benefiting by making informed choices
2 about quality and cost.

3 To that end, we have introduced and
4 continued to develop new products to encourage
5 members and referring providers to choose
6 high-quality, cost-efficient providers and
7 services.

8 Thanks to the drafters of Chapter 305,
9 health care reform 2.0, the Commonwealth has a
10 broad process underway for understanding and
11 tackling health care costs, including these
12 hearings. The complexity of the problem is a
13 mess, but let's not forget that a blueprint for
14 addressing the affordability of health care was
15 written and approved by the Payment Reform
16 Commission, which voted unanimously to move away
17 from the current fee-for-service system to a
18 global provider system with significant quality
19 incentives.

20 While a sound transition to global
21 payments statewide will take time, it must start
22 immediately. And state government has a central
23 role to play in ensuring a successful transition.
24 Each step we take in Massachusetts on the way to

1 health care reform requires collaboration among
2 all the stakeholders to contain the underlying
3 medical costs driving premium increases while
4 continuing improving quality.

5 Blue Cross will continue to propose and
6 implement meaningful, sustainable solutions, and
7 we look forward to working with you as you
8 develop your recommendations. Thank you.

9 **SPEAKER GAUNYA:** Good afternoon,
10 everybody. My name is Mark Gaunya, and I'm the
11 president of the Massachusetts Association of
12 Health Underwriters, a not-for-profit organization
13 representing over a thousand licensed employee
14 benefit professionals and thousands of employers
15 and their employees all across the Commonwealth of
16 Massachusetts.

17 It is my distinct honor and privilege to
18 be invited to participate in this panel of
19 distinguished health care experts, and I greatly
20 appreciate Commissioner Morales' invitation. By
21 way of background, I've spent the better part of
22 my life in and around health care and believe my
23 21-year career in the provider, payer and
24 employee benefits brokerage and consulting

1 industries will provide this panel with a unique
2 perspective on the rising health care cost
3 challenge and how it effects the consumers of
4 Massachusetts.

5 Initially, I planned to talk about the
6 rising cost of health care and some of the facts
7 and figures behind that, but I think the
8 panelists you've heard before today and the
9 panelists you've heard so far have already talked
10 about that in great detail.

11 I will share with you that we are No. 1
12 in the nation with 97.4 percent of our residents
13 insured versus the national average of 83
14 percent. Our health plan designs though are 27
15 percent richer on average, meaning they have
16 lower deductibles and lower out-of-pocket cost
17 sharing, and our health care costs on average are
18 15 percent higher.

19 Solving the rising health care cost
20 challenge is akin to working with a Rubix Cube
21 because it has many moving parts and possible
22 combinations to get the right answer. But one
23 thing is clear, health insurance is expensive
24 because health care is expensive.

1 In 2009, three of the top four health
2 plans posted significant operating losses ranging
3 from 10 to \$150 million. In Q1 2010, health plan
4 rate increases for small groups, those with less
5 than 50 employees, average between 25 and 40
6 percent. In a weak economy, employers and
7 consumers are demanding answers and solutions.
8 The question is, Are we looking in the right
9 places and asking the right questions?

10 Let's start with the defining health
11 care trend and its components. Simplistically,
12 health care trend is the combination of provider
13 unit costs, a utilization of health care products
14 and services by consumers. By most estimates,
15 health care trend in Massachusetts is roughly
16 between 10 and 12 percent, and it's broken down
17 75 percent unit cost, 25 percent utilization or
18 units of service.

19 Next let's provide a high level overview
20 of the Massachusetts health care system in
21 spending trends for privately insured residents.
22 No. 1, there's greater availability in our market
23 and use of more expensive academic medical
24 centers and use of outpatient hospital-based

1 facilities for some services that could be
2 provided in less costly settings.

3 No. 2, higher number of specialty
4 doctors rather than primary care doctors and a
5 health care system dominated by academic medical
6 centers, both of which tend to provide more
7 expensive care.

8 No. 3, a higher concentration of doctors
9 in academic medical centers compared to national
10 averages.

11 And No. 4, increases in spending were
12 more heavily directed toward outpatient hospital
13 services which saw growth in unit costs and
14 utilization of imaging services, medical
15 procedures and cancer therapies.

16 With that information in mind, let's
17 examine the Attorney General's Office report on
18 January 29th, which analyzes health care costs,
19 trends and cost drivers. The report clearly
20 identifies and concludes that contracting
21 relationships between health care providers and
22 health plans is the primary driver of health
23 insurance premium increases.

24 More specifically, the report suggests

1 that No. 1, reimbursement rates for health care
2 providers are consistently inconsistent within
3 the same geographic area and amongst providers
4 offering similar services.

5 No. 2, reimbursement rates are not
6 correlated to the quality of care delivered, the
7 sickness or complexity of the population being
8 served, the mix of Medicare and Medicaid
9 patients, the classification as an academic or a
10 research facility or the underlying cost
11 structure.

12 No. 3, reimbursement rates are
13 correlated to market leverage based on size,
14 geography and brand.

15 No. 4, variation in total medical
16 expenses is not correlated to the methodology
17 used to pay for health care services; i.e., the
18 difference between discounted fee-for-service and
19 global payment. In fact, the report suggests
20 global payment can cost more depending on how the
21 program is structured.

22 No. 5, increases in reimbursement rates
23 are the primary driver of health plan premium
24 rate increases, not excessive health plan

1 administrative costs.

2 No. 6, the commercial health plan market
3 has been distorted by contracting practices that
4 perpetuate market leverage and prioritize
5 competitive position over consumer value.

6 But what about the consumer of health
7 care products and services? What is their role
8 in this challenge? I intended on Tuesday and I
9 was distraught by the notorious absence, being
10 briefly mentioned in most of the discussions
11 relative to the consumer's role in health care.

12 In our view, consumers also play a very
13 big role in the rising cost of health care, and
14 their lifestyle choices and health care decisions
15 are required to bend the health care trend.

16 Twisting the cube to solve the problem:
17 In every industry, sound economic models address
18 both supply and demand to improve quality and
19 control costs. Supply-side solutions in health
20 care include, but are not limited to, restricting
21 provider network access, changes to the
22 reimbursement methodologies between providers and
23 health plans, availability of innovative products
24 and services; and 4., government regulation.

1 Demand-side solutions include, but are
2 not limited to, consumer engagement, education
3 and empowerment through the fundamental
4 principles of transparency of cost and quality,
5 individual responsibility to make healthy
6 lifestyle choices and informed purchasing
7 decisions, and the opportunity to be physically
8 and financially better off if you make those
9 informed choices.

10 Other cost containment tools include
11 tort reform to reduce the impact of medical
12 liability and to curb the defensive practice of
13 medicine, the evaluation of state-mandated
14 benefits; and finally, the evaluation of minimum
15 creditable coverage standards under the Mass.
16 Healthcare Reform Law.

17 As the AG accurately pointed out, and we
18 fully agree, working together, policymakers,
19 health plans, providers, employers and consumers
20 can deliver the health care quality and value
21 that the people of Massachusetts deserve. Thank
22 you.

23 **SPEAKER GLYNN:** Good afternoon,
24 Commissioner Morales, Assistant Attorney General

1 Johnson, our moderator and other members of the
2 panel. My name is Tom Glynn. I'm the chief
3 operating officer for Partners Healthcare. To
4 provide some context for my perspective, perhaps I
5 should mention that I served in the Clinton
6 Administration under Bob Reich as Deputy Secretary
7 of the U.S. Department of Labor which oversees
8 ERISA.

9 Earlier in my career, I served as Deputy
10 Commissioner of the Massachusetts Department of
11 Public Welfare, as it was then called, under
12 Governor Dukakis during the time when Medicaid
13 was under the Welfare Department.

14 Partners Healthcare System welcomes this
15 community dialogue on the many factors
16 contributing to rising health care costs in
17 Massachusetts and at the national level. We look
18 forward to working with all key stakeholders,
19 clinicians, insurers, employers, consumers and
20 state government leaders to develop
21 evidenced-based sustainable long-term solutions
22 to ensure that Massachusetts patients maintain
23 their access to high-quality care that is also
24 affordable.

1 We applaud Senate President Therese
2 Murray for bringing the issue of health care
3 costs to the forefront of public discussion
4 through Chapter 305. We congratulate Governor
5 Patrick and the Attorney General for their
6 ongoing data-driven review and analysis of
7 factors influencing health care costs, premiums
8 and the structure of the current marketplace.

9 Such data is needed to take a deliberate
10 and effective approach to reforming the state's
11 health care system, an economic engine that is a
12 critical component of our economy, employing one
13 out of every six workers and contributing a
14 significant 13 percent of the state's gross
15 domestic product, gross state product.

16 Without the correct diagnosis of the
17 problem, we are likely to get the wrong remedy.
18 We therefore applaud the Patrick Administration
19 for commissioning several analyses and engaging
20 multiple experts to peel away the complex layers
21 of the health care cost puzzle in an effort to
22 develop solutions; including, 1., the RAND
23 Corporation, August 2009 analysis, Controlling
24 Health Care Spending in Massachusetts: An

1 Analysis of Options;

2 2., the Division of Health Care Finance
3 and Policy reports that came out recently;

4 3., the hearings conducted by The
5 Division of Insurance;

6 And 4., the analysis commissioned by the
7 Health Care Quality and Cost Council in September
8 that evaluates the impact of freezing provider
9 payment rates and health insurance premiums.

10 Today, Partners Healthcare would like to
11 endorse the rigorous and thoughtful analyses
12 conducted by the RAND Corporation and the cost
13 trends reports done by Brandeis' Heller School.
14 These reports highlight important factors
15 contributing to health care spending and premium
16 increases in Massachusetts and provide
17 data-driven analysis from which evidence-based
18 solutions should be developed in considering
19 policy options.

20 These analyses also highlight the
21 challenges of recommending a one-size-fits-all
22 policy solution when, as the report shows, there
23 is great variability what is driving cost trends.
24 There is also great variability in the ranges of

1 predicted savings and sometimes limited empirical
2 and theoretical evidence to reach definitive
3 conclusions.

4 Partners Healthcare supports the rate
5 analysis which shows the following ways to
6 address the cost pressures. 1., bundle payments;
7 2., medical home; 3., health information
8 technology.

9 The Brandeis health care cost trend
10 report provides a well-balanced, comprehensive
11 analysis of factors contributing to health care
12 costs in Massachusetts. We acknowledge that
13 these factors play a role in underlying cost
14 trends.

15 As the analysis indicates, 1.,
16 Massachusetts has a high concentration of medical
17 personnel, including specialists and residents.
18 2., Massachusetts has a large proportion of care
19 provided by academic medical centers. 3., due to
20 the state's commitment to ensure access care to
21 all, we can probably say that Massachusetts has
22 the highest insurance rate in the country with
23 over 97 percent of the population insured.

24 And we agree, as the report states, that

1 broader coverage and more generous benefits
2 contribute to the cost growth as well. 4., the
3 predominant payment method for paying physicians
4 at hospitals in Massachusetts is via
5 fee-for-service methodology which provides
6 limited incentives for providers to increase
7 efficiency or improve quality of care.

8 Partners agrees that fee-for-service
9 payments not linked to performance are a factor
10 contributing to increasing cost trends. That's
11 why Partners has pay for performance contracts
12 with major commercial payers. Dr. Gary Gottlieb
13 will discuss further details tomorrow about the
14 limitations of the current fee-for-service system
15 and how we propose to change it in his testimony
16 in the panel on solutions.

17 The challenges of managing health care
18 costs is a national issue and not unique to
19 Massachusetts. In this light and as the Brandeis
20 report highlights, the growth trend for health
21 care spending in Massachusetts is similar to the
22 U.S.

23 In addition, after adjusting for higher
24 income, housing, utility and other necessities,

1 Massachusetts personal health care spending is 13
2 percent of gross state product, ranking not at
3 the top, but in the middle of the 50 states.
4 This is especially striking given that the
5 Massachusetts labor, utility, and real estate
6 costs are significantly higher than the national
7 average.

8 As the community dialogue continues and
9 the pressures mount to push policymakers to
10 develop solutions, we need to ensure that the
11 true drivers, true key drivers of cost growth are
12 the targets of policy solutions aimed at curbing
13 them.

14 The Patrick Administration, the
15 legislature, the Attorney General and all
16 stakeholders have a challenging task ahead of
17 ensuring that their solutions will reduce the
18 rate of spending in Massachusetts while
19 preserving the economic engine that is so
20 critical to our workforce, our patients and our
21 future economic prosperity.

22 We look forward to working with the
23 Patrick Administration, the Attorney General and
24 the Legislature to identify key health care cost

1 drivers in Massachusetts and to develop solutions
2 to tackle them.

3 **SPEAKER LODGE:** Good afternoon. Thank
4 you, Commissioner. I appreciate the opportunity
5 to be here. Hopefully, I'm going to try to say
6 some things that are a little bit different than
7 everybody else has repeated. Actually, some of
8 this may be more ad hoc since I had some
9 experiences today that may apply.

10 My background, if you read my biography,
11 I'm the President and CEO of Winchester
12 Healthcare Management which is the parent company
13 of both a hospital and a medical group. We are
14 managing both physicians and a hospital and
15 working hard to become an integrated delivery
16 system at least at our level.

17 We support -- and frankly, we're, for
18 those of you who don't know where we're located,
19 we're about eight or nine miles outside of
20 Boston. We have some significant competition.
21 We send a truck into Storrow Drive everyday to
22 try to plug up the tunnels down there to make
23 sure no one can get in, but that doesn't always
24 work.

1 We've actually decided that what we
2 should do is focus on patient experience at
3 Winchester Hospital. We're actually proud to be
4 named the No. 1 employer in Boston for two years
5 in a row, really by two significant, both the
6 Boston Business Journal and the Boston Globe.
7 Part of that is not just because we want happy
8 employees; but the truth is where we think we can
9 be different is if you come to Winchester
10 Hospital, hopefully you're going to have a better
11 patient experience.

12 If you take a look at our cost structure
13 or public data, whatever public data you have out
14 there, we actually think we're very, very
15 competitive right now. And we think we're paid
16 relatively fairly. So we're not talking about
17 that the payment methods are very, very
18 different.

19 In my history, so people are aware, I
20 used to have some of Andrew's responsibilities
21 back in the old days when things were very, very
22 different. I think this is an important fact
23 that people ought to realize. Things have
24 changed in the last twelve to thirteen years.

1 When I did contracting on behalf of Blue
2 Cross and Blue Shield, A., there were selective
3 networks, significant selective networks. People
4 were restricted where they could go and where
5 they could receive services. And frankly, many
6 of those selective networks grew to 500,000
7 people and excluded many high-cost providers when
8 they existed at that time.

9 Commercial rates back in those days, by
10 the way, were negotiated, for the most part were
11 about 75 percent of costs. Medicare, on the
12 other hand, was paying almost 130 percent of
13 cost. That has almost completely reversed itself
14 in the last twelve years.

15 So what you have is government payers
16 who used to subsidize commercial payers, and now
17 you've got commercial payers subsidizing
18 commercial payers. A very big issue.

19 Dr. Ginsburg mentioned, which I think is an
20 important solution going forward, is that those
21 societal costs, whatever they may be, teaching,
22 research, Medicare shortfalls, Medicaid
23 shortfalls, Free Care Pool supports maybe ought
24 to be through a tax, a direct tax rather than

1 hiding that tax in a premium that gets inflated
2 out there. It could go a long ways to trying to
3 solve this problem of what things are. Then
4 people would really know what they're getting
5 when they buy health insurance.

6 The other thing, I've heard all kinds of
7 conversations about what needs to be done to
8 providers and provider payments, whether it's
9 capitation or whatever else you come out with. I
10 had a very interesting conversation this morning
11 along the Mass. Business Roundtables Health Care
12 Advisory Group, and there happened to be a major
13 plan there and a major employer there.

14 And they were discussing one of the
15 employees from that employer. And that employee
16 had found out that because of some contracting
17 thing, they had to receive or should be receiving
18 their services in a particular group of
19 caregivers. And it was kind of news to them
20 because their product really doesn't sell itself
21 as that. It sells itself as a full access
22 network.

23 So the employer representative said, you
24 know, this is very difficult for us to deal with.

1 And the insurance company said, well, you know,
2 the provider group really should manage that in
3 making sure that the patient is educated. What I
4 recommended is not the provider group's
5 responsibility alone.

6 It is the employer group's
7 responsibility to educate. It is the health plan
8 that sells it to educate and make sure that
9 everybody is party to, in fact, what this
10 arrangement ought to be in the end.

11 I do think -- I used to be the Chair of
12 the Mass. Hospital Association. It actually had
13 put out a very good paper recently. I will
14 endorse it. It does say as we're going down the
15 payment reform path, there are benefit changes
16 that need to be implemented, and they need to be
17 part of the old package.

18 So if you're going to do capitation,
19 have a product that aligns with the provider
20 contracting strategy so that everybody, whether
21 you're the beneficiary, you're the provider or
22 you're the insurance, you're all aligned; and
23 nobody's confused about what they ought to be
24 doing. The rules of the game are clear.

1 I will say one last thing, and this
2 comes from my experience with my daughter who was
3 a student of Regina Herzlinger. And she
4 discussed a program in Switzerland. And one of
5 the things that we don't talk enough about is how
6 we encourage and truly encourage people to have a
7 healthy lifestyle.

8 So in Switzerland, the program that
9 worked there, I may not have this perfectly
10 right, but I'll be short. I have one minute.
11 Essentially you buy insurance. You as an
12 individual buy insurance in the marketplace. You
13 buy it for five-year periods of time.

14 And you will get a rebate on your
15 premium for different lifestyle events, A., if
16 you don't smoke; this one I don't particularly
17 like, you don't drink; and you maintain your
18 weight; you exercise. So good lifestyles, you
19 could get up to as much as a 50 percent return on
20 your premium for adhering to it.

21 How it works, all the details of it, but
22 it really says in the end it can't just be a
23 provider reimbursement strategy. It's not a
24 health plan issue all on its own. It is a

1 partnership much like the partnership that got
2 put together with getting 97 percent of this
3 population insured.

4 And no matter what we talk about today,
5 everybody ought to be pretty proud of that. I
6 mean, this is the state in the union that does
7 that. If we've accomplished nothing, we have 97
8 percent of this population insured, and that's a
9 great victory. That's it. Thank you.

10 **SPEAKER PINKHAM:** Good afternoon. I
11 guess no time for pleasantries because I have five
12 minutes, so. My name is Julie Pinkham. I'm the
13 Executive Director of the Massachusetts Nurses
14 Association. We represent 23,000 registered
15 nurses and health professionals in Massachusetts.

16 We have 70 percent of the registered
17 nurses or 70 percent of the acute care hospitals
18 in Massachusetts, we represent the registered
19 nurses. We've taken the opportunity to analyze
20 the wage data.

21 I thank you very much to the Division
22 for providing all the data. Also, I wanted to
23 thank Judy Rothchild for assisting all of my
24 staff who have been working diligently to take a

1 look at the wage data and answer two specific
2 questions.

3 The first is, Are nursing wages a cost
4 driver in the escalation of health care costs in
5 Massachusetts? The second question we looked at
6 is, Is the data of the Attorney General and the
7 Division reflective of the reality experienced by
8 the registered nurses?

9 So focusing on the first, at the
10 beginning of the decade, RN wages in
11 Massachusetts and Boston and national were
12 similar. However, unlike RN labor workforce
13 participation nationally, RN labor workforce
14 participation in Massachusetts fell and continued
15 to decline.

16 In the MNA's view, it was a combination
17 of the failed RN work redesign strategies that
18 led to a three-year decline in Massachusetts. RN
19 labor force participation began to improve when
20 hospitals abandoned work redesign models that
21 substituted unlicensed personnel for registered
22 nurses.

23 The demand caused by the failed redesign
24 strategies and the subsequent nursing shortage

1 led to substantial RN wage increases both to
2 recruit and to retain RN's. When RN wages
3 declined to unacceptable levels and/or working
4 conditions deteriorated, the RN labor workforce
5 participation declined. Hospital vacancy rates
6 subsequently rose, triggering a familiar cycle of
7 RN shortages and understaffing in Massachusetts
8 hospitals.

9 We found in our analysis that the RN
10 wage cost as a percent of the total hospital
11 budget has been between 17 and 18 percent for the
12 past five years. I've attached some charts to
13 the testimony in which we've actually taken the
14 various hospitals and divied them up in a variety
15 of different ways, whether by size, teaching,
16 geography, every different disproportionate
17 share, we looked at it pretty much every
18 different way that we could.

19 And the range went from 12.5 to 17.5
20 percent of the total expense. And that again, as
21 I say, it's been flat. We also took a look at RN
22 wage increases from 2005 to 2010 and found that
23 they were on pace with inflation and most
24 recently have now begun to decline.

1 In '05, it was roughly 4 percent. It
2 has now declined to 2.5 percent. It's important
3 to recognize that there's a marked variation in
4 RN wages across Massachusetts. The MNA's
5 analysis and the data from the U.S. Bureau of
6 Labor Statistics concur that higher RN wages in
7 Massachusetts cluster around Boston teaching
8 hospitals.

9 MNA RN wage markets are primarily
10 defined by geography and teaching status. Boston
11 hospitals must compete for RN labor workforces to
12 work in a tertiary care teaching setting
13 regardless of the relative profitability of the
14 hospital. This is similarly true throughout
15 geographic areas of the state.

16 Contract negotiations for wage rate are
17 patterned by geography and teaching status more
18 so than profitability and/or network affiliation
19 status. The union and non-union wages are not
20 significantly different. Non-union facilities
21 will pattern their wages to remain market
22 competitive with union wages as contracts are
23 negotiated.

24 For non-union facilities this is both a

1 recruit and retention effort and a no-doubt
2 method to deter nurses from unionizing. The
3 MNA's analysis of RN wages, hospital demographic
4 and financial data from the Division found that
5 RN wages were significantly associated with
6 teaching status.

7 Hospital profit was also a relevant
8 factor, though the impact as a percentage of
9 hospital expense remains stable or flat. MNA's
10 analysis did not find an association between RN
11 wages and total hospital charges or hospital
12 charges for separate medical and surgical
13 procedures.

14 Succinctly, the analysis of the
15 Department of Labor, the Division of Health Care
16 Quality and Finance, MNA wage data reveals the RN
17 wages are not connected to the concerning
18 increases of the Massachusetts health care costs.

19 I'm going to skip because I'm going to
20 lose here. We then focus on the second question,
21 and that is, Is the relative experience of the
22 data found by the AG that of the experience of
23 registered nurses in Massachusetts, specifically
24 quoting the prices paid to the hospitals do not

1 correlate to the acuity or complexity of the
2 cases handled by the hospital as measured by
3 hospital case mix index.

4 The nursing profession has long
5 recognized that using diagnostic-related groups
6 or DRG's or CMI case mix index as a proxy for the
7 complexity of acuity of patient care is a
8 problem. Specifically, DRG's and CMI's failed to
9 account for the intensity of nursing care needs
10 for the patients.

11 I'm now skipping. I have attached an
12 article by Welton to my testimony. We found that
13 in this article, adding nursing intensity
14 adjustment to the existing inpatient billing
15 improved in explaining the variance of
16 Massachusetts hospital cost values, 12.7 percent
17 for all payers.

18 The MNA believes the conclusion of the
19 preliminary report that the variance of hospital
20 costs can't be explained by the severity of
21 complexity of care as flawed by the indices used
22 in the analysis which failed to account for the
23 intensity of nursing care.

24 While this will not account for all of

1 the variances, it is significant. Addressing
2 this component along with other components
3 effecting price variance provides a cumulative
4 approach that is, in our opinion, the way to
5 address the issues rather than seeking a syllabic
6 resolution.

7 Lastly, we would say -- I'm speaking
8 over this. Lastly, we would say that it's ironic
9 that we're speaking today in terms of RN wages
10 and the cost of RN's when the only reason why you
11 actually stay in a Massachusetts hospital from
12 our standpoint is because you need 24-hour
13 clinical RN supervision. Otherwise, your care
14 would be delivered outside of the hospital.

15 But yet, in part, and when we look at
16 the budget, nowhere can you find RN costs. They
17 are lumped in under, you know, general costs.
18 It's not teased out. We would hardly recommend
19 that not only the issue of nursing intensity be
20 looked at, but also that the licensed RN costs
21 are indeed peeled out from the budget so that
22 they can be analyzed. Thank you.

23 **SPEAKER KANE:** Thank you. I've been
24 asked to comment on the, to diagnose the reasons

1 for rising health care costs. I guess because
2 I've had some national experience with the
3 Medicare Payment Commission, Advisory Commission,
4 which by the way, I cannot represent their
5 opinions. I can only represent my own.

6 But I can start to perhaps draw some
7 parallels between what's going on in
8 Massachusetts and what's going on nationally. I
9 can only say that comparing Massachusetts to
10 what's going on in the nation doesn't necessarily
11 make us better or worse because what's going on
12 in the nation is actually quite problematic as
13 well.

14 So basically the long-run costs of
15 escalating health care, long-range causes have
16 been pretty well identified I think in the last
17 few speakers as well as the prior speakers; and
18 they include national wealth, advancing in
19 technology, getting older, inflation, and even
20 being insured does encourage escalating health
21 care costs.

22 Since the early 1960's, since we
23 basically had Medicare and Medicaid, health care
24 costs have grown 2 percent or more faster than

1 GDP. And it's been fairly studied for the last
2 40 or 50 years. While policymakers obviously
3 don't want to reduce wealth or advances in
4 technology, there remain still some very
5 important and potentially influential leaders
6 that we could use to help keep health care costs
7 growth affordable.

8 These include policies that relate price
9 levels to value that modify payment units to
10 encourage providers to provide provider
11 value-based care including the appropriate use of
12 technology. And finally, policies that encourage
13 value-based benefit design that promotes
14 appropriate consumer decision-making.

15 When I use the word *value* in this
16 context, I mean affordable, accessible and
17 efficiently delivered care that delivers the best
18 possible health care outcomes to the citizens of
19 Massachusetts.

20 In other words, I don't necessarily
21 think health care policy should guarantee
22 employment or maintain an industry that isn't
23 affordable in providing the kind of care that we
24 think our citizens deserve.

1 In terms of pricing levels, I think the
2 Attorney General's study recently released does
3 show the differentials across hospitals and
4 physicians are a function of provider market and
5 political power and not value as I defined it
6 earlier.

7 Similarly, political leverage effects
8 prices that even Medicare pays. For instance,
9 academic medical centers receive add-ons to their
10 DRG rates for indirect graduate medical education
11 that's twice as high as the empirically justified
12 costs which sends \$3 billion in additional
13 revenue to academic medical centers nationwide
14 every year in excess of their empirical costs.

15 This enables them, in fact, to compete
16 better against community hospitals that don't get
17 these kinds of payments. Similar disparities
18 based on political leverage and payment design
19 flaws are evident in the Medicare relative value
20 scale which have gotten worse over time and have
21 resulted in payment rates that pay some
22 specialists more than 200 percent more per hour
23 than primary care physicians without any other
24 explanatory variables.

1 This has contributed to a distorted
2 supply of physicians nationwide. In
3 Massachusetts, for instance, only about 35
4 percent of physicians report that adult primary
5 care is their only specialty; and the disparities
6 in access to primary care seem to be worsening.

7 Payment equity within systems as well as
8 between payers and providers may also be required
9 in order to push delivery system toward greater,
10 higher value care. For instance, one of my
11 physicians -- I trained physicians to become
12 managers in this health care system, and they're
13 constantly writing me little anecdotes to support
14 things they've learned in our program.

15 One of them wrote, "My health system has
16 just decreased the dollars per RVU so that my
17 salary will not go up when more RVU's are
18 attached to follow-up care and management." This
19 is a doctor who does a lot of cognitive,
20 non-procedural type care.

21 "Meanwhile, the procedurals are staying
22 higher. For instance, my RVU's went from \$50 to
23 44, while the orthopedists and pain management
24 specialists stayed in the \$60 range. Recently, I

1 saw a lady who had gone from an orthopedist to a
2 neurosurgeon specializing in spines who did a
3 lumbar and cervical spinal fusion."

4 "The patient continued to get weak. She
5 saw me, and I diagnosed that she had ALS. She
6 didn't need the fusions after all. My visit cost
7 \$150. Her fusions cost over \$50,000. The
8 comparison is priceless."

9 Both the Attorney General's report and
10 the Special Commission on Payment Reform
11 recommend reducing pricing disparities that are
12 not based on value. While I agree with the
13 Attorney General that global rates alone will not
14 address disparities and the growth of commercial
15 rates, it would be extremely shortsighted to
16 focus only on the level of pricing and not on the
17 incentives that the pricing unit presents to
18 providers.

19 While utilization may account for only
20 25 percent of the increase in commercial rates in
21 Massachusetts in recent years, it accounts for a
22 much greater percentage of the increase in per
23 capita spending in the Medicare program which
24 administers prices, does not negotiate them. So

1 obviously, utilization will be a much bigger
2 problem for them.

3 While price increases accounted for
4 about 20 percent of the increase in per capita
5 Medicare spending over the last ten years, volume
6 per beneficiary increased by another 70 percent.
7 For physicians services, volume has grown even
8 faster on a per capita basis.

9 While there are many reasons for the
10 rapid growth in outpatient utilization, it's
11 pretty clear that that the utilization of
12 outpatient is contributing quite a bit more than
13 just the pricing increases alone.

14 Much of the long-term increase in health
15 care costs is attributed to new technology, some
16 of which add great value, and others of which are
17 of dubious values. Many researchers have
18 suggested that new technologies adopted in the
19 last decade may not have the same value that they
20 had in prior decades.

21 Unfortunately, it is not often obvious
22 which technologies fall into which category.
23 Both the state and the federal government need to
24 foster comparative effectiveness, research and

1 dissemination.

2 Finally, the incentive to use new
3 technologies which often, new technology which
4 often carries higher price tags than the
5 technologies they replace is much greater under
6 the fee-for-service incentives than under more
7 value-based and bundled than the much bundled
8 payment systems.

9 I'm going to move on now to talking a
10 little bit about payment on fee-for-service.
11 Just to conclude, it's inherently inflationary
12 and doesn't respect the value-based payment
13 principles. Finally, in terms of value-based
14 benefit design, both Medicare and most private
15 sector insurance coverage offer weak to
16 nonexistent incentives for patients to make
17 appropriate and value-based choices in health
18 care.

19 Deductibles and copays are often
20 indiscriminate and discourage both high value and
21 low value care. Recent analysis of Medicare cost
22 sharing, for instance, highlights the differences
23 in utilization between beneficiaries with and
24 without Medigap policies.

1 Medicare beneficiaries with Medigap
2 policies spent between 17 and 33 percent more,
3 depending on the policy, than those without
4 Medigap policies. We can't tell whether the
5 spending, additional spending was appropriate or
6 not or whether the non-Medigap spending was
7 appropriate.

8 So I look forward to discussing these
9 issues and also with Andrew Dreyfus agree that
10 the Special Commission on Payment Reform which
11 met for six months on hard plastic seats without
12 lunch did issue a report that I think gives the
13 state a blueprint for how to modify the payment
14 system to encourage much better value for our
15 health care dollar. Thank you.

16 MODERATOR TURNBULL: Thanks to all of
17 you. So I'm going to, I have some questions that
18 I want to ask. Any of you want to ask questions,
19 there are people circulating with white note
20 cards. So please join in.

21 So I'm going to start with the Division
22 and the AG's report that showed prices rather
23 than utilization are the primary driver leading
24 to increasing health care costs. A number of

1 you, including Andrew and others seem to concur
2 with that.

3 Tom, I want to start with you. In your
4 comments, you just said that we should focus on
5 the true key drivers of health care cost growth.
6 So I wanted to know, What do you think those are?

7 SPEAKER GLYNN: I think that Nancy did a
8 good job laying out some of them. I mean, one of
9 them is technology. Another one of them is the
10 aging of the population. Another one is the
11 increasing utilization.

12 I think that price has a role in that.
13 I just don't think it placed quite the role that
14 some people have suggested. And I think that the
15 national studies that have been done looking at
16 this over time, you know, the CBO did an analysis
17 about two years ago kind of looking at the three
18 major national studies; one of them done by David
19 Cutler who some people know locally, suggested
20 that technology was probably responsible for
21 roughly half, and the other factors were
22 responsible for the other half.

23 So you know, I just think it requires a
24 little bit of an understanding these different

1 pieces of the puzzle

2 MODERATOR TURNBULL: Andrew, in your
3 testimony, you said price accounted for I think it
4 was 50 percent of your pricing?

5 SPEAKER DREYFUS: Yes.

6 MODERATOR TURNBULL: Do you agree with
7 Tom or not?

8 SPEAKER DREYFUS: We made a distinction,
9 and the Attorney General's report captured this
10 that none of the other plans did which is we had
11 three components of trend. One was what we call
12 pure pricing. Another one was utilization we've
13 talked about, and the third was the mix.

14 Then the Attorney General may have just
15 been a kind of taxonomy question. They included
16 mix as part of price which is a reasonable
17 conclusion. We think it's important to segregate
18 because as you start to think of what are the
19 interventions, you need to understand at that
20 level.

21 But I'd like to have a few thoughts
22 about price and about disparities. One thing is
23 about, as I think both Paul Ginsburg and Stuart
24 suggested and Nancy, that if we constrain price,

1 we will see utilization come back. And there's
2 strong evidence of that over time.

3 And so unless we have a system which
4 tries to ask physicians and hospitals to take
5 accountability for both price and utilization,
6 which global payments do, then I don't think
7 we're going to get at the root of the problem.

8 The other thing that I thought was very
9 helpful in the Attorney General's report but not
10 discussed, at least in the part of the hearings
11 that I've seen, are a focus on total medical
12 expense which combines to some extent price and
13 utilization.

14 First of all, you see a smaller
15 disparity on total medical expense than you do
16 simply on price. So for example, it's also what
17 most contributes to premium. We increasingly are
18 using tiering and tiered networks, which are part
19 of the value-based design that I think several
20 people recommended.

21 We tier primary care physicians. We
22 don't tier them based on price. We tier them
23 based on total medical expense. I think that's
24 an important point. I guess, finally, I'd say

1 that when we look at price, let's not always
2 assume that the lowest price is bad.

3 I understand we heard from Lawrence
4 General Hospital about the serious financial
5 challenges they face by being a low-paid hospital
6 both from public and private payers. But we need
7 low-cost providers in our states in order to
8 design the kind of value-based products that I
9 think everyone are calling for.

10 In some ways, I think Dale presented
11 what he considered his hospital as a kind of
12 moderate cost alternative. And I worry if we
13 just focus on price what we'll end up focusing on
14 and we'll see is a kind of race to the top where
15 all the lower paid physicians and hospitals will
16 essentially seek higher payments, and we'll have
17 a race to the top.

18 Finally, I was interested in what Nancy
19 said about Medicare because we did a quick
20 analysis to look at what are the disparities in
21 payment rates to hospitals in Massachusetts from
22 Medicare which is a regulated, fixed-priced
23 system. And we found they're pretty substantial;
24 not quite as substantial as they are in the

1 private commercial market, but substantial
2 nonetheless.

3 So whether we had a regulated system or
4 we have a competitive system, we still have a
5 disparity which is why we need to look at the
6 total cost of care which we think is what global
7 payments begins to do.

8 MODERATOR TURNBULL: You packed a lot
9 into that, some of which we'll come back to again.
10 Dianne or Dale, you were leading in, so.

11 SPEAKER ANDERSON: Yes, I would like to
12 make a comment. I actually agree with you,
13 Andrew. I think we do need low-cost providers in
14 the state but not underpaid for value. I think
15 that's an issue that's been clearly brought forth
16 by the AG's report and certainly by the various
17 panelists we've heard so far.

18 We believe, for example, that we can
19 really help be a solution to that by, you know,
20 I'm intrigued by the notions of some of the
21 leveling pricing according to value and some of
22 the things that have been discussed today because
23 if we could at least true up some of the pricing
24 in the system so that we can provide the same

1 level of care and infrastructure and information
2 technology, we can continue to be even higher
3 value and be even more efficient than we are
4 right now.

5 MODERATOR TURNBULL: That's helpful.
6 Dale, did you want to talk?

7 SPEAKER GLYNN: I don't know if I'm
8 allowed to have another?

9 MODERATOR TURNBULL: You can have another
10 until I tell you you can't.

11 SPEAKER GLYNN: I do want to pick up on
12 something that Dale said which I think it relevant
13 to this part of the conversation about what is
14 driving up costs. He made the observation about
15 what's happened with Medicare reimbursement over
16 the years. And just to kind of reiterate, in the
17 early 1990's, it was about 130 percent of cost.

18 Now it's down to around, depending on
19 who you talk to, it's certainly less than 90. I
20 think in the report, that one of the DHCFP
21 reports it says that the national average for
22 private payers is 132 percent of cost in order to
23 subsidize Medicare losses and Medicaid losses.

24 So one of the factors in driving up the

1 cost of the premium is the fact that we're
2 getting about 70 cents on the dollar for Medicaid
3 and about 90 cents on the dollar from Medicare.
4 Roughly, 18 percent of the money that we charge
5 Andrew is to make up for the losses in Medicare
6 and Medicaid.

7 And so as those get worse, there's more
8 pressure on the private side of the equation. I
9 think Dale put this idea in play in an important
10 way, and I think that needs to be factored into
11 the equation particularly given, you know, the
12 fact that there's more pressure at the federal
13 level now on the Medicare budget and, you know,
14 the Medicaid budget doesn't seem to be improving
15 in terms of cents on the dollar for hospitals.

16 MODERATOR TURNBULL: Well, let's pick up
17 on the cost shifting. I was going to come to that
18 later, but -- I think in the last day and a half,
19 we've heard actually two different stories about
20 cost shifting. One we've heard that private
21 health insurance premiums are going up because
22 public payers are underpaying. And so that
23 suggests that we don't have a cost problem. We
24 have a revenue problem.

1 We heard not so much today but on
2 Tuesday from Deborah Chollet, and actually a
3 little bit today because of the MedPAC article
4 that, in fact, cost shifting is a market failure
5 and that it's a consequence of the market
6 leverage.

7 And that Deborah said on Tuesday that
8 the hospitals are revenue maximizers, and they
9 will act in ways to maximize their revenues. So
10 if they're in a competitive market, they can't
11 shift costs. If they have market leverage, they
12 can shift costs; and that, in fact, that market
13 power is allowing some hospitals to be
14 inefficient.

15 So we have these two different. One is
16 that there's a revenue shortfall, and the other
17 is there's inefficiency which is resulting in
18 higher cost. And I think this is a debate that
19 we have a lot with public payers in particular
20 that the problem with talking about cost shifting
21 is that it accepts that the underlying costs are
22 reasonable, appropriate and efficient; and
23 therefore, if there is a shortfall in covering
24 your costs, it's on the revenue side and not on

1 the cost side.

2 Nancy, I'm going to pick on you to talk
3 about because this is an issue that MedPAC I
4 think has looked at. The article that's in
5 Health Affairs Today on MedPAC kind of makes this
6 case. I think actually the AG found some of this
7 as well, that there's actually explicit
8 provisions in some contracts to allow cost
9 shifting to occur. What do you have to say about
10 that?

11 SPEAKER KANE: Yes. I think from the
12 perspective of MedPAC, I don't know what's in the
13 article because I haven't seen it today, but I
14 know in our report in March and actually pretty
15 regularly in the last couple of years, we've been
16 trying to understand why some hospitals make money
17 on Medicare.

18 We've looked at them and tried to
19 understand how it is that if Medicare is such a
20 terrible payer that people make money on
21 Medicare. It looks like the No. 1 reason is
22 they're unable to spend more and get it
23 subsidized by the private sector payers.

24 So if you look at hospitals that make

1 money on Medicare and are actually relatively low
2 cost relative to the national average, they have
3 a non-Medicare margin of -5% on average between
4 2003 and 2007. So in other words, they are
5 unable to cost shift because they don't have
6 enough private sector, or they don't have the
7 market power; or they have a lot of Medicaid. So
8 they're just unable to make money on their
9 non-Medicare patients.

10 The average Medicare margin for those
11 providers is about break-even. So obviously,
12 they've been able to live within the Medicare
13 payment. That suggests that when you can get
14 more money from the private sector, you spend
15 that level as opposed to the reverse that you set
16 your prices to cover your efficient cost.

17 The other thing we've tried to do, the
18 staff has tried to do at MedPAC is understand
19 whether these hospitals that are relatively
20 efficient provide worse care. And we can't find
21 any indication of that at all. In fact, if
22 anything, it looks like metrics aren't perfect on
23 quality, but the metrics that are available
24 suggest that these hospitals that make money on

1 Medicare are actually quite high quality.

2 So there is at least from the Medicare
3 perspective a very strong sense that the
4 hospitals that don't make money on Medicare are
5 basically because they're inefficient.

6 On Medicaid, which is a different
7 subject altogether, probably Medicaid does pay
8 less than an efficient hospital's costs. On the
9 other hand, let's talk about where Medicaid comes
10 from. Medicaid is a state, federal, taxpayer
11 financed program. Most of our hospitals don't
12 pay taxes, at least not property and not state
13 income and often not federal income, and not
14 federal income taxes.

15 So one question is, What is the quid pro
16 quo for being tax exempt? Should you still get
17 every penny that you spend back from the
18 taxpayers, or do you owe the taxpayers a little
19 something back because you are tax exempt? And
20 you know, this is something I spent quite a bit
21 of time doing trying to understand the
22 relationship between the value of tax exemption
23 and the value of what hospitals provide in
24 benefit.

1 Obviously, people don't all agree on
2 what benefits are. It's pretty clear that the
3 Medicaid and the shortfall of Medicaid would fall
4 into that type of expectation that impacted that
5 hospital that you would expect. You should be
6 actually maybe losing a little on Medicaid
7 because you're tax exempt.

8 So one question is why do for-profits
9 like Medicaid, they also provide quite a bit of
10 Medicaid. So we're a little bit wondering where
11 the value of the tax exemption is. So you know,
12 in sum, it's not clear to me that the need to
13 shift costs because you're underpaid as an
14 efficient hospital is a good excuse for raising
15 your rates to the private sector.

16 MODERATOR TURNBULL: Yes, Tom.

17 SPEAKER GLYNN: So I think that I'm
18 following Nancy's argument, and I certainly agree
19 with a good chunk of it. But I think if I say,
20 well, 18 cents of every dollar that we charge
21 Andrew is to make up for losses, that that is an
22 order of magnitude impact on what the cost
23 structure is.

24 I think if it were less, then maybe it

1 would be a little bit more of an argument. At
2 the same time, I would agree with what both
3 Nancy's are suggesting which is, Do we have a
4 cost problem? Yes. Do we need to work on it?
5 Yes. Are we working on it hard enough? No. So
6 I don't think they're mutually exclusive.

7 I think it's possible that it is driving
8 up costs and we should do something about our own
9 costs. I would also say that it's tricky when
10 you try to compare even among teaching hospitals,
11 so I pulled some of this data because I thought
12 it was interesting for purposes of this
13 conversation.

14 So you know, we keep track because we
15 always view ourselves as competing nationally and
16 locally. So in terms of research dollars, we can
17 compete nationally. In terms of attracting
18 residents, we compete nationally. In terms of
19 patients, it's more local.

20 So we keep track of what the other
21 national institutions are doing, and we kind of
22 use the U.S. News List because it's not a list we
23 made up. So for 2008 fiscal year, BJC, which
24 many of you know is in St. Louis, had an

1 operating margin of 3.7 percent. Cleveland
2 Clinic had an operating margin of 3.8. Johns
3 Hopkins in a regulated state had an operating
4 margin of 4.5. Penn had an operating margin of
5 4.8. Duke, currently run by a former Brigham &
6 Women's Hospital chief of medicine, had a margin
7 of 6.0.

8 MODERATOR TURNBULL: I'm sorry you let
9 him get away, you know.

10 SPEAKER GLYNN: Partners, in case anyone
11 wants to know how Partners fits into that, 1.7.
12 People are able to do different things in
13 different situations with largely the same
14 portfolio of commitments. We think the 1.7 is a
15 rather modest number. As Nancy suggested, people
16 have been able to do different things in working
17 with these same programs.

18 MODERATOR TURNBULL: Anyone wants to
19 chime in?

20 SPEAKER LODGE: I guess the only thing
21 I'd add is it probably would be helpful for us all
22 to learn how these people are making money on
23 Medicare and whether they are Massachusetts
24 hospitals that are incorporated in that. I know

1 that we regularly benchmark our total cost against
2 lots of competition.

3 And we don't find anybody around here
4 that's more cost effective than us. But it's
5 just surprising. I'd love to see who can do it
6 and how they do it, and if they can do it in this
7 state in particular because there are different
8 rules and regulations that apply here that may
9 not apply in other arenas, that that may be
10 different.

11 So understanding it, I think if this is
12 really going to be a partnership, you ought to
13 learn from those successes. If that's something
14 that works and is transferrable, and God knows
15 somebody ought to come out and educate us on how
16 to do it because all of us every year for running
17 whatever we're running, trying to manage our
18 costs very, very effectively.

19 We think we do a reasonable job. We are
20 responding to whatever the demand is in most
21 cases, even though that's hard to do. Matching
22 this up I think is maybe something you take away
23 from this, how you educate people to make
24 progress because I think we all want to be

1 successful. If there's a track record out there
2 that can do it, we've got a new consulting
3 company.

4 MODERATOR TURNBULL: Andrew, you want to
5 say something?

6 SPEAKER DREYFUS: We've talked a lot
7 about cost structures. We haven't said anything
8 yet. I just would like to introduce it that we
9 know there's a lot of unnecessary spending in the
10 system and that today under our current
11 fee-for-service model, if an outpatient practice
12 at one of Tom's facilities successfully manages a
13 patient with chronic illness and they're not
14 admitted to the hospital, the reward is that
15 system gets paid less.

16 If that patient is admitted to the
17 hospital and contracts a preventible infection,
18 the reward to the system gets paid more. Clearly
19 those incentives are backwards. So one way to
20 think about how would we reduce the cost to the
21 system is how do we create incentives to take
22 what the clinical community has agreed is a lot
23 of unnecessary harmful care. How do we take it
24 out?

1 MODERATOR TURNBULL: I want to talk a
2 little bit about disparities and payment. I think
3 that's one of the most interesting things that
4 comes out of the Attorney General's report and
5 some of the Division work. Andrew, I want to
6 direct this to you. Just to remind people, both
7 the Division and the AGO study find these
8 tremendous payment variations, cross providers
9 that aren't related to quality, patient
10 complexity, teaching status, disproportionate
11 share hospital status.

12 I want to frame this in the context that
13 we've been relying in Massachusetts and actually
14 in the country as a whole over the last 20 years
15 or so on private negotiations between health
16 plans and providers to be a major vehicle for
17 cost control.

18 As I think both Stuart and Paul observed
19 that model for a number of years for reasons we
20 could argue about, but we won't. It did result
21 in some moderation of health care cost spending.
22 But it's clearly kicked back up.

23 Andrew, I actually wanted to start with
24 you. It's kind of on the health plan.

1 Particularly, you represent the biggest insurer
2 in the state. You have more than 3 million
3 members. I think that's about 60 percent of
4 insured people.

5 If there's any insurer in the state who
6 should have market power to negotiate with
7 hospitals and physician groups, it should be Blue
8 Cross. Yet, and Stuart said it's unfair, but
9 through the beauty of Google, you can find things
10 people actually said in the past.

11 In the Globe series back in December of
12 2008, the story says that you say that you
13 shouldn't -- the Globe said that you shouldn't be
14 blamed for the run-up in health insurance prices.
15 You always try to cut the best deals possible,
16 that you know that there are a number of
17 hospitals that get paid more, but there's a limit
18 to what you can do.

19 And you say you have to stay very
20 attuned to the balance of the market, that you
21 are not a regulator, that market fairness is a
22 public policy issue beyond the control of any one
23 company. So I guess I would say, do you or don't
24 you have the market clout to be able to deal with

1 the provider market as it's evolved?

2 SPEAKER DREYFUS: That was a very
3 thoughtful comment that I made.

4 MODERATOR TURNBULL: I thought it was
5 good. Your comments are always thoughtful, so you
6 get quoted a lot. So the Google search was very
7 long.

8 SPEAKER DREYFUS: To answer your question
9 directly, and then I'll elaborate. I don't think
10 we have the market power alone to eliminate the
11 disparities that are displayed on that chart. I'm
12 not sure if that chart is our rates or not. I
13 think the disparities are very troubling, and I
14 think they need to change. And the question is,
15 How do you do that?

16 I think we heard from Paul, I mean, he
17 was saying a lot of things I was thinking is that
18 we actually have a mixed regulated and
19 competitive system today. Half of the typical
20 hospital's revenue comes from public payers whose
21 rates are set; although, as I noted earlier, they
22 vary pretty significantly. Then half of the
23 typical hospital's revenue come from commercial
24 payers.

1 We do work very hard to negotiate the
2 lowest price we can possibly get. I would just,
3 the same way that Tom suggested they look at
4 national numbers, we compete with national plans;
5 and benefit consultants, which advise national
6 employers, are very closely monitoring the level
7 of discounts that plans like Blue Cross can
8 achieve. And we're constantly trying to
9 negotiate the best deal.

10 As was noted in the earlier panel,
11 there's not been much appetite in Massachusetts
12 for broad networks, excuse me, for narrow
13 networks which would exclude the hospitals either
14 because of geography or reputation or brand or
15 the array of services they offer, are required to
16 be in most networks.

17 What I'd say has changed or just my
18 thinking has advanced since I offered that quote
19 to the Globe, which was probably 18 months ago at
20 least, was the potential I've begun to realize
21 through payment reform. I do think, and I was
22 interested to note that the Center For Studying
23 Health System Changes was just in Boston last
24 week, and they heard it according to Paul Allot

1 (phonetics) about our alternative quality
2 contract which is beginning to assert a
3 disruptive influence in the market.

4 I just want to give you one or two
5 anecdotal examples. There's been a lot of talk
6 today about what can we do with hospitals and
7 what incentives are we to offer to consumers.
8 There's not been much discussion on what
9 incentives we can offer to physicians.

10 In fact, in most health care markets,
11 it's physicians who are deciding where patients
12 go to get their care less consumers. There's
13 very few consumers who when getting advice from a
14 physical, you should have this procedure at
15 hospital X, will then intervene, look on-line,
16 check out a list, check what their infection
17 rates were and then change and override the
18 doctor's decision.

19 Since we introduced our alternative
20 quality contract, we've started to hear from
21 primary care physicians who now have the kind of
22 data that's displayed publicly here which we
23 supplied to them, and they are beginning to
24 understand the economic and the quality

1 consequences of where they send their patients.

2 And they most often are beginning to
3 choose to send their patients to lower cost,
4 high-quality providers which should over time
5 lower the cost of care.

6 So I think the disparity is troubling.
7 I think it's hard for one plan alone to do it. I
8 think it's time to think about what the proper
9 balance of regulation and competition should be
10 in the state. But we think that new payment
11 models have to be at the center of it, whether
12 you had a regulated system or a competitive
13 system.

14 MODERATOR TURNBULL: Okay, we'll come
15 back to that in a bit. Tom, do you agree with the
16 AG's report that there's no correlation between
17 price and quality care?

18 SPEAKER GLYNN: No.

19 MODERATOR TURNBULL: Okay. Thank you for
20 that answer. Say more.

21 SPEAKER GLYNN: Can I say another word
22 about what Andrew said before I turn to quality?

23 MODERATOR TURNBULL: Yes, you may.

24 SPEAKER GLYNN: So I think that again

1 kind of going back to the opening comments that
2 Dale made, you know, I think you have to put these
3 things in some perspective. I don't know, you
4 know, a lot of times what's happening here is
5 reflecting what's happening nationally.

6 So it is true that in the mid-nineties,
7 the early and mid-nineties, the HMO's were
8 successful in negotiating better deals. But it's
9 also true that that was true all over the
10 country. It's also true that the reason for
11 that, as Dale explained, was we were getting 130
12 percent from Medicare. So we could afford to
13 make these concessions.

14 So for example, when Dr. Theer
15 (phonetics) was in Washington fine tune
16 negotiating about the Balanced Budget Act, Jack
17 Luge, then the head of the Office of Management
18 and Budget under President Clinton said to him,
19 you signed a bad deal with Harvard Community
20 Health Plan. That's not my problem.

21 What was true was that the Brigham had
22 signed a deal where Harvard Community Health Plan
23 got roughly, I'm doing this from memory, so I may
24 be off, a 40 percent discount on 25 percent of

1 their patients.

2 So you know, we can look at that and
3 say, wow, that's when the HMO's really had a lot
4 of clout. Okay, maybe they did. But it's also
5 true that the fact that Medicare was able to
6 underwrite effectively these deals is not an
7 irrelevant factor. Then in 1997, as we alluded
8 to, the Balanced Budget Act passes, and the feds
9 say, we're not going to do that anymore.

10 So they took away the subsidy that they
11 had been putting into the hospitals that was
12 making it possible for the HMO's to have this
13 market clout. So you know, I think some of these
14 economic trends are as important as looking at
15 the political situation. So that's Point No. 1.

16 Point No. 2, I think if you take a step
17 back and you say -- when you talk to people
18 around the country about the quality of
19 leadership we have in the HMO's here, they're
20 quite surprised. A., we have one former head of
21 an HMO running for Governor. I think this person
22 who is the No. 2 under that person for many, many
23 years is probably one of the most respected guys
24 in the public and private sector in health care.

1 We have another health plan that's run
2 by a prominent national democrat who's also been
3 very successful running that company; and at Blue
4 Cross, we have had a history of civic leadership
5 running that company including now Andrew; in the
6 past, Peter Mead; et cetera. So to me, to say
7 well, these guys haven't had much ability to
8 influence the market, I don't know.

9 Last, and most importantly, I just want
10 to read from an article that was in the Globe on
11 January of 2009 because I think it suggests that
12 perhaps the pendulum has swung back more than we
13 realize. So I'm quoting.

14 "The more recent Partners and Blue
15 Cross contracts settled over the summer provides
16 more modest increases, Partners officials said in
17 an interview this week. The contract calls for
18 increases in payments for medical services in the
19 range of 5 to 6 percent a year which is roughly
20 medical inflations, said Partners chief financial
21 officer, Peter Markel."

22 So you know, I would go on to say, when
23 we see in the paper some of these other
24 increases, it's a little bit of a mystery to our

1 physicians exactly how our contract is driving up
2 these double-digit increases that we read about.

3 So I don't know if this situation is
4 quite as sometimes it is characterized based on
5 kind of my view of the history and kind of the
6 situation that we're in right now based on what
7 was said in this Globe article

8 MODERATOR TURNBULL: Actually, can I tell
9 you one thing Paul Levy said about it this
10 morning? Maybe you and others can respond about
11 it. One thing he said about payment disparities
12 in particular was that they've created a dynamic
13 where more highly paid systems are able to recruit
14 more doctors who then channel more patients to
15 these highly paid places.

16 Is that -- Dianne or Dale, maybe first
17 could you comment on that? Have you seen this
18 happening within your community?

19 SPEAKER LODGE: Fortunately, no. But do
20 we think that we are under pressures because some
21 of the local physicians are being paid at a
22 differential rate? Yes. And are we employing
23 more physicians and probably having to underwrite
24 that because of that factor? Yes, in order to

1 retain things.

2 But you know, knock on wood, we're not
3 losing physicians to just solely higher pay.
4 Part of it is we've taken action to make sure
5 that we develop a competitive both lifestyle and
6 compensation, and we still manage our overall
7 costs just about as effectively as anybody.

8 But it does create pressures, and we've
9 had pressures on nursing salaries and other
10 things because we're so close to Boston, and we
11 do not pay Boston rates. We compete in a
12 different marketplace. But salaries within
13 Boston are significantly different than what they
14 are in our marketplace. And that pressure is
15 there for us to keep our employees there.

16 MODERATOR TURNBULL: Dianne, how about
17 Lawrence?

18 SPEAKER ANDERSON: Yes, I'd say that is
19 definitely a factor for us because I think our
20 physicians -- we have sort of a mixed bag of
21 physicians. We have a lot of small practices.
22 Then we have some larger groups that have
23 organized.

24 We have some that have joined up with

1 some of the IPA's of the tertiaries. There's a
2 tremendous amount of competition. We know that
3 we have probably somewhere around a 30 percent
4 out migration from our area that goes, again,
5 we're not that far from Boston, that goes, you
6 know, into Boston primarily.

7 And these are largely cases that could
8 stay and get the same excellent level of care in
9 our hospital and with our physicians. So I think
10 it's definitely a factor. And Paul's comment
11 really resonated with me as far as the challenges
12 that we deal with.

13 MODERATOR TURNBULL: Mark, how do you see
14 this problem among those employers who are part of
15 this program or the employee benefit folks,
16 payment disparities?

17 SPEAKER GAUNYA: With all due respect to
18 Dr. Ginsburg's comments earlier about
19 consumer-driven health plans, I think he shared
20 with the audience a very basic structure of a
21 consumer-driven health plan. I tend to kind of
22 peel away, with all due respect to my
23 distinguished panel who's a lot more educated than
24 I am and a lot more sophisticated with how they

1 run their businesses, I'm talking with employees
2 and employers everyday. I want to just kind of
3 focus on one element, and that is the power of the
4 consumer.

5 I believe the power of the consumer to
6 be very strong in every industry, including
7 health care. In fact, most estimates, and I'm
8 not an economist, but consumers are the driving
9 force behind a growing economy or a not growing
10 economy. And the reality is until they get
11 engaged in the health care cost discussion, until
12 they get educated about what health care costs
13 really are, and until they have responsibility to
14 behave differently, they won't.

15 So I look at it and say, I ask the
16 following question, and my clients are asking me
17 this everyday, Why is it so difficult to share
18 the price? Why do I have to find out about the
19 cost of a service after I have it? Why when I
20 call my doctor or I go visit with my doctor can
21 he not tell me or she not tell me how much
22 something costs?

23 If I want to go buy a car today, Mark,
24 I'm not going to go do it today. I'm actually

1 going to get on-line. I'm going to do research.
2 I'm going to have all kinds of access to
3 information at my fingertips using our wonderful
4 technology you referenced, Google. Google,
5 amongst other tools, can be and should be used by
6 the consumers as long as they have the incentives
7 to want to get engaged.

8 How I see it is I usually break a
9 problem down to two buckets. Is it a mechanical
10 problem, or is it a philosophical problem? So I
11 ask the panel, Do we have a philosophical issue
12 of transparency, No. 1? Do we not want to share?
13 I know Dr. Ginsburg said if we do share, that
14 could have the overall impact of raising costs.
15 That could be a near-term problem.

16 I think a long-term solution is
17 consumers actually getting engaged, asking
18 questions and making informed and educated
19 decisions and weighing out because they do have
20 the ability to do this. They do in every other
21 area of their life, cost and quality, to come up
22 with a value structure for themselves.

23 So is it mechanical in a sense that
24 health plans' contracts preclude them from

1 disclosing price? Is it that providers don't
2 want to say I'm charging \$3,000 for this MRI when
3 I know the next facility down the street is
4 charging 500 for the exact same machine?

5 I had one client who asked me, what did
6 it cost, I wanted to go to the bone marrow
7 transplant place. I had a cotton swab done for
8 my DNA testing. I got a bill from the insurance
9 company, and it cost \$4,300. \$4,300 for a cotton
10 swab for a DNA test. Why is that the case?
11 Well, if the person had the information on the
12 front end, maybe they would have made a different
13 choice.

14 The question I ask, Is it philosophical,
15 mechanical; or is it a combination of the two?

16 MODERATOR TURNBULL: Okay, Andrew, so is
17 it philosophical or mechanical. You said in your
18 comments you were concerned about a race to the
19 top. You often hear that concern that consumers
20 will, both that that will cause a race to the top
21 in terms of negotiation, but there's also a
22 concern I think that some people express that
23 consumers in the absence of any other information
24 will think that a more highly paid provider is a

1 better provider.

2 And so that kind of creates a race to
3 the top. I'd be curious actually after you
4 finish your comments what Dianne has to say.

5 SPEAKER DREYFUS: I think everyone is --
6 I don't think there's a philosophical disagreement
7 about the power and potential strength of
8 transparency. We just have to be careful. While
9 I agree, Mark, that that's the kind of ideal state
10 we ought to work to, I still think that physicians
11 often drive the decision, patient decision-making
12 more than patients.

13 I am concerned about the race to the
14 top. I have even in the last 40 hours gotten
15 calls from a few hospital officials who are
16 curious about where, you know, the race that
17 appeared in the Attorney General's report; and
18 perhaps in some ways that's a good way to churn
19 things up.

20 MODERATOR TURNBULL: And we want to
21 negotiate them down.

22 SPEAKER DREYFUS: I haven't gotten that
23 call, Nancy. I've been waiting for that call for
24 five years. So I think there is a concern about

1 that. I think ultimately we do have to get to
2 this value question.

3 I think one of the things that we are
4 increasingly experimenting with, and it deals
5 with both the MRI question Mark just raised and
6 the other, is exposing consumers more to those
7 places where they can make those decisions.

8 I don't think if my father needs to go
9 to the emergency room, he's not going to sit
10 around. He doesn't even own a computer. He
11 can't get onto a computer to make these
12 decisions. He's going to go where he's
13 comfortable going, where he's used to going,
14 where the ambulance is directed to take him.

15 On the other hand, we pay \$700 for an
16 MRI in most free-standing facilities, and about
17 1,400 when they're on a hospital campus or a
18 hospital outpatient facility. I understand that
19 hospitals will tell us that they have other
20 higher costs that get built into that price.
21 That seems like a big differential.

22 I think we need to design products
23 increasingly where consumers have an option and
24 if they want to go to a higher priced facility

1 that they bear some of that responsibility.
2 Actually, at Blue Cross, we now, that's one of
3 the plans we offer to our own our associates.
4 I'm in it. So I'll give you a report at the end
5 of the year how it's going.

6 The differential is substantial. The
7 difference between going from that first tier
8 hospital to a third tier hospital is hundreds if
9 not thousands of dollars. So we need to
10 experiment with those products. As I believe Jim
11 Roosevelt said earlier today, there's not been a
12 great take-up. But we've seen a growth, for
13 example, in our new tiered product from about 10
14 or 15,000 members to 50,000 members in the last
15 quarter and a half.

16 SPEAKER LODGE: I'd add, I believe
17 everything that you've said as long as the
18 consumer also has to pay some of the differential,
19 just not knowing the price. By the way, could I
20 get that \$1,400?

21 SPEAKER DREYFUS: There they go again.

22 SPEAKER LODGE: I just thought it was a
23 good idea.

24 SPEAKER ANDERSON: I really find that

1 it's inexcusable really that our hospital and our
2 physicians would be paid significantly lower rates
3 for the same procedures. And we want to hold
4 ourselves accountable as far as quality and
5 transparency.

6 We're working very, very hard to do
7 that. But it's just, it's hard to understand why
8 without any other basis as far as quality
9 outcomes or other key factors, why that isn't
10 true. We're not even asking to be paid as high
11 as Partners, but at least maybe Winchester. It
12 just doesn't really make any sense.

13 I think that for the patients in our
14 area, if they knew the price, and it did make a
15 difference to them as far as what they had to
16 pay, and they had all the information as far as
17 the difference in quality for the physicians that
18 they were going to and the hospital that they
19 would probably make wiser choices if that's how
20 the system was structured.

21 MODERATOR TURNBULL: Okay. We have
22 actually a couple of questions related to this.
23 So this one is to the providers. Are you willing
24 to provide true transparency to cost of care and

1 the quality to the public? The public can't
2 engage in the cost of their care and
3 responsibility of their care if they have no idea
4 of how much things cost.

5 And then Andrew, a challenge to you. Is
6 Blue Cross Blue Shield a market dominant payer?
7 Do you think you have an obligation to your
8 members to educate them that your payments vary
9 wildly, that your payments don't reflect quality?
10 How do you justify this dramatic and until
11 recently secret price disparity to providers?

12 SPEAKER LODGE: So can I try the
13 providers?

14 MODERATOR TURNBULL: Please do.

15 SPEAKER LODGE: One of the discussions, I
16 haven't gotten to listen to Barbra Rabson this
17 morning, but at another meeting on different
18 measures of quality. Quality is, there are all
19 kinds of different measures out there. If we
20 could somehow start to standardize what are the
21 quality measures, you know, across all payers and
22 what everybody is interested in seeing, then I
23 think you'd have an effective tool that consumers
24 could evaluate far more effectively.

1 But your gut is each insurance plan
2 having their flavor of quality. MHQP which
3 frankly is an independent body, which said to me
4 it's a good set of quality. There's someone
5 doing it on an independent basis with others. If
6 we could have one set and people could focus on
7 that, because the truth is measuring quality in a
8 hospital, you could have thousands of different
9 measures that no one would really be able to
10 understand.

11 Frankly, most of what's out there is
12 mostly process oriented and not outcome oriented
13 yet. I do hope some day it becomes more outcome
14 oriented. And lastly, you know, our -- I don't
15 think we have any trouble posting our prices and
16 letting our prices be out there and be
17 transparent out there.

18 I have no arguments with anything that
19 has been published to date. I think our prices
20 are competitive and fair, and so I don't think
21 there's any issue. The fact is if consumers were
22 engaged in doing price shopping, I think as an
23 organization, we would do extremely well. So we
24 wouldn't have any problem at all of having it

1 posted out there.

2 It may not be true of everybody. We'd
3 like it to be out there. We'd like those
4 differentials to be identified and actually have
5 whoever is choosing it pay the difference so they
6 can start to pick things more on price and
7 whatever quality measures we come up with. I
8 think that's a good step with everyone

9 MODERATOR TURNBULL: Andrew, do you think
10 you have an obligation to make your payments
11 public and say they're not related to quality?

12 SPEAKER DREYFUS: First of all, I would
13 challenge that they're not related to quality at
14 all. I agree with the overall point that the
15 Attorney General made that as a general rule,
16 they're not.

17 But what we've been trying to do
18 increasingly is tie our payments to quality,
19 whether that's through pay for performance
20 programs or especially our new alternative
21 quality contract. That was the whole piece, the
22 whole point behind it was to both moderate the
23 growth in costs and to try to improve care. The
24 way to do that is to focus on payments of

1 quality.

2 MODERATOR TURNBULL: What proportion of
3 your payments are related to quality?

4 SPEAKER DREYFUS: I'd say it depends on
5 how you define it. In the alternative quality
6 contract, it could be up to 10 percent of those
7 payments. It's a little bit less -- one of the
8 challenges here is there aren't wildly accepted
9 quality measures for a whole range of illnesses.
10 Let's take cancer for example. There aren't yet
11 the standard set of measures around quality care
12 for cancer that we could link payment to.

13 Back to the original point of the
14 question, Do we need to be more transparent about
15 this? Yes. We'll actually be over time giving
16 our members on-line tools to help them understand
17 the cost and price of care and the consequences,
18 especially within our new products of choosing
19 different tools.

20 I would also say that more than half of
21 our customers are self-insured. And while
22 they're not posted on-line, we're paying claims
23 for them which they get to see. And so they're
24 acutely aware of the prices that we pay for care

1 and constantly pressuring us to keep them down.

2 MODERATOR TURNBULL: Lois, you have a
3 question.

4 MS. JOHNSON: Just a follow-up question
5 about the AQC, and we hope to learn more about
6 that particular model. In terms of going forward
7 then if your interest is to tie payments to
8 quality, when you set the budget for the AQC, are
9 you looking at historical quality performance; or
10 are you just talking about going forward and sort
11 of measuring the prospectively tying some payments
12 to quality? But when you set that budget, are you
13 setting it based on quality performance?

14 SPEAKER DREYFUS: No, you're absolutely
15 right. It's going forward. So what we tried to
16 do, and we could go into as much detail as you're
17 interested in, one of the key decisions that we
18 had to make when working on the AQC is to try to
19 distinguish it from change what didn't work with
20 past capitation models. Part of that was there an
21 attempt to reduce payments at the beginning.

22 We made an attempt to try to start, to
23 start people where they were, to try -- we didn't
24 think we'd have any luck getting people to accept

1 a quality based contract if we said the first
2 thing you'd have to do is reduce the cost. So
3 what we do is we estimate at the beginning what
4 their quality performance is today.

5 How much additional payment that would
6 generate for them and then show them the
7 potential as they improve their care over time
8 how they can earn more in quality. At the same
9 time, they make a commitment to reduce the
10 overall cost of care, the trend that we're so
11 focused on here over the course of the five
12 years. Most agreements are five years. In most
13 cases, we're asking them to cut the medical trend
14 in half.

15 MS. JOHNSON: If as we've seen with
16 respect to the overall trend it could be as much
17 as 75 percent, but depending on how you parse the
18 taxonomy of medical trend, at least 50 percent of
19 that is price, how does global payments or in the
20 AQC version of it moderate price over time?

21 MODERATOR TURNBULL: I guess part of it
22 might be in terms of talking about part of what
23 we're talking about today, what might the premium
24 impact be of the AQC?

1 SPEAKER DREYFUS: We have 25 percent of
2 our members right now who are affiliated with
3 primary care physicians who have chosen this form
4 of payment. To the extent that over time, A., we
5 can design products around those caregivers, and
6 to the extent that they are successful as we hope
7 and as they're designed to reduce the rate of
8 growth in half, then that will translate into
9 lower premiums for those employers whose employees
10 are participating in those contracts or who we
11 hope over time will buy products that are
12 organized around these set of providers who have
13 made an agreement at the beginning to reduce the
14 rate of growth.

15 I think underlining your question is a
16 deeper question which is, Is there a potential
17 for the alternative quality contract to lock in
18 existing price structures and payment
19 disparities? I think there was a potential for
20 that which is why it wasn't something that was
21 probably appropriate for some higher paid or
22 higher priced providers in our network.

23 What we tried to do and to the extent
24 that some of the providers who entered in this

1 early made deeper commitments to bring their
2 costs down, we're trying to move our providers
3 towards a network average. But again, we didn't
4 want to have them re-experience the perils of
5 capitation where physician practice has lost
6 money right at the beginning. I don't know if
7 that's getting too granular.

8 MODERATOR TURNBULL: I want to shift
9 gears. Actually, I want to come to a different
10 issue that was talked about in the AGO's report;
11 that is, the impact that expanding the footprint
12 of the academic medical centers is having on cost.

13 The same scenarios where there's a
14 tension in the system between the business
15 interests of individual providers and perhaps
16 what's good for the system as a whole in terms of
17 costs. Paul talked about this a little bit this
18 morning when he talked about duplicative services
19 and things.

20 Tom, if you could talk about just as one
21 academic medical center to help us understand
22 what some of the business imperatives for
23 Partners and other academic medical centers are
24 expanding into the suburbs? Are there capacity

1 shortages in the suburbs you're trying to
2 address? Is there crisis of quality? Are there
3 scale economies that you get by expanding?

4 SPEAKER GLYNN: Well, I think that you
5 have to start with kind of the patient's
6 experience. So let's pick on Danvers as an
7 example because a lot of people are probably
8 familiar with it.

9 So North Shore Medical Center has two
10 campuses, one in downtown Salem and the other one
11 in a residential neighborhood in Lynn. The Salem
12 campus is quite old. And in fact, it may be one
13 of the few remaining campuses, Dale may know more
14 exactly, of community hospitals in Massachusetts
15 or in the region, it may be one of the few
16 hospitals that up until extremely recently had
17 quads, which are rooms with four beds.

18 So we're pretty confined into the space
19 that we have there, and in the same theme with
20 the residential neighborhood in Lynn. So we had
21 already had two satelllites that had been
22 established by Salem Hospital, one for cancer and
23 one for women's health.

24 So the notion was to try to expand those

1 two centers kind of in one location and make it
2 more convenient for people who are trying to get
3 either Salem or Union Hospital. We picked
4 Danvers. We picked Route 128 because of the
5 accessibility issues.

6 It's also the case that, you know, if
7 you go back over the 25 years, there were a lot
8 more patients now who need to be treated with
9 either radiation therapy or chemotherapy who
10 require kind of short stays. So the kind of
11 models that we built in these campuses 30 years
12 ago of inpatient stays and visitors doesn't
13 really fit a lot of people coming in for short
14 treatments and then leaving. So you need a
15 different kind of a model. That did not lend
16 itself to either the campus in Salem or in Lynn.

17 So that was really I would say more of
18 the major focus of why we undertook that. You
19 know, I think that there is a concern that both
20 of those campuses serve most of the low-income
21 people on the North Shore. And so it was an
22 effort to try to make sure that we were getting a
23 reasonable patient mix at the end of the day
24 since we've been subsidizing both of those places

1 pretty much, since shortly after it came into the
2 system.

3 So I would say those were kind of the
4 two main factors that, as I remember, this is a
5 decision we made five or six years ago. So I may
6 not have a perfect recollection. But I think
7 that's kind of an example.

8 MODERATOR TURNBULL: Was that the same,
9 for example, in Foxborough?

10 SPEAKER GLYNN: Well, we might as well go
11 around 128. So you know, in Milford, there was a
12 joint venture done with the Milford Hospital.
13 It's South Shore Hospital there was a joint
14 venture done with the South Shore Hospital and
15 Dana Farber.

16 In Foxborough, that is an area where
17 there's population growth unlike the rest of
18 state, and we were asked to take a look at an
19 opportunity because of the fact that Foxborough
20 is kind of in the middle of several other service
21 areas. So we decided to try something that we
22 hadn't tried before which is open up a facility
23 and try to serve the people in the southern part
24 of the marketplace.

1 Historically, the Brigham has had a
2 pretty healthy representation of people from the
3 south. I forget the exact number, but there's a
4 decent number of people who are being served at
5 the Foxborough facility who used to be served at
6 the Brigham. I just don't remember off the top
7 of my head.

8 MODERATOR TURNBULL: Andrew, when that
9 happens, when they're expanding a footprint, what
10 impact does that have on your premiums? Are you
11 paying at teaching hospital rates? So what's the
12 cost impact of those?

13 I'm curious if Blue Cross has ever
14 thought some of these expansions or investments
15 were not needed? Have you ever said that you
16 wouldn't pay for them? Have you ever made any
17 attempt to stop this through your market power?

18 SPEAKER DREYFUS: First of all, I would
19 say that those questions have been a point of
20 great, intense negotiation in our negotiations
21 with systems like Partners. And by the way, there
22 are other academic facilities in Boston that are
23 doing the same thing.

24 MODERATOR TURNBULL: Yes, Tom got to have

1 a seat today, so.

2 SPEAKER DREYFUS: Right, and there are
3 others doing that. I think we're very concerned
4 if there's an attempt to charge what I would call
5 academic level rates which are higher for a
6 variety of reasons, some of which we've noted, and
7 some of which we've because there are a variety of
8 costs built into more complex organizations and
9 community facilities. We've tried to fight that
10 very strongly.

11 MODERATOR TURNBULL: How's it gone?

12 SPEAKER DREYFUS: Some success. I also
13 think this is an area, you know, we haven't talked
14 much about back to the balance of regulation and
15 competition. We've not had a very strong voice in
16 health planning in the state. We've not had a
17 very strong certificate of need program for a
18 number of years. I think those programs have to
19 come more into play as we think about what are the
20 best resources in the community.

21 MODERATOR TURNBULL: So Dale, has the,
22 have some of these expansions effected Winchester?
23 If so, how?

24 SPEAKER LODGE: Not on volume of patients

1 for us right at the moment. We have lost staff
2 to, because in fact, you know, Boston rates come
3 out to the suburbs. And you know, people either
4 choose they want to work in Boston, or they want
5 to work in the community. We have lost staff, and
6 we lost some significant staff initially.

7 It kind of balanced off over the years,
8 but that's probably been the immediate impact on
9 us directly. I know other community hospitals
10 are seeing a very different story. They're
11 losing volume to, I mean, let's face some reality
12 here, Mass. General and the Brigham & Women's
13 Hospital have absolute fabulous brains, and
14 there's no question on the data about that.

15 When they come out into the community,
16 they bring that brand out there. That does
17 attract patients, and it competes directly with
18 community hospitals. Knock on wood, we haven't
19 seen it personally at Winchester. But I
20 certainly hear in anecdotally from other local
21 community hospitals

22 MODERATOR TURNBULL: Julie, you're
23 shaking your head.

24 SPEAKER PINKHAM: Because we represent 70

1 percent of the hospitals, we're seeing nurses on
2 both sides of the issue. So there's no doubt that
3 the opening of an institution up in Danvers by
4 Partners is beneficial in terms of the North
5 Shore, but it did have a negative impact on
6 Northeast Health Systems.

7 I mean, so on the one hand, we're
8 growing in one area, and the other hand, as
9 nurses, we're sitting down and realizing that
10 they're probably going to shutter that
11 institution. The wages were less at Northeast
12 than they might otherwise be.

13 At the end of the day though what I find
14 ironic is I'm not interested in throwing Partners
15 under the bus because most of the time you're
16 probably looking to pick up hospitals that
17 wouldn't survive. Most of the reality is that's
18 the model. I don't know that we can demonize the
19 success because that's the model. It's a
20 competition model.

21 I don't think any of us were frankly
22 surprised. We literally sat down as an
23 organization when this started and got groups
24 together and took the geography of Massachusetts

1 and said, I'm going to tell you right now, these
2 hospitals are going to merge, and which networks
3 are they going to go with. And we're continuing
4 to do it right now.

5 I think the bigger question for us is
6 when is it going to stop? I do agree with the
7 DON, whoever raised it here --

8 MODERATOR TURNBULL: It wasn't Tom. It
9 was Andrew.

10 SPEAKER GLYNN: It wasn't me.

11 SPEAKER PINKHAM: The question, I guess
12 it's not, you know, that's the model. If they can
13 build a facility and whatever, that's fine i
14 guess. But the question is, Do we need it, No. 1?
15 And what's its impact with surrounding
16 institutions?

17 We don't actually have an assessment of
18 health care needs in the State of Massachusetts.
19 We close a facility, and we don't know whether or
20 not that's in the public's best interests at all.
21 If that ER shuts down and my heart attack now
22 puts me at a higher risk of death, that's
23 troublesome to me. That's not really the
24 discussion here.

1 I guess in the transparency of
2 information, I think it's a great thing. But the
3 general public isn't going to go on Google and
4 even understand half the language that's there.
5 They want to know exactly who you know and where
6 you've been to, to what facility. The public
7 relations stuff that is out there, the media
8 dollars that are spent right now, an incredible
9 waste as far as we're concerned. That is driving
10 the public.

11 There's less effort on transparency and
12 data than there is on billboards, television ads
13 and newspaper ads, and I think that's definitely
14 driving the population into certain services, you
15 know, the Davinci billboards and whatnot. I
16 mean, these are the things that I think in health
17 care are part of the cost drives as well.

18 But the people that are utilizing the
19 system to the success of the system aren't the
20 demons. It's the policy, itself, that's
21 problematic. And in the meantime, I think right
22 now as long as if one hospital shuts down, one
23 more hospital shuts down, these community
24 hospitals, I don't think we're served well at

1 all.

2 We shut down 30 after we deregulated,
3 and I understood that we were over-bedded. I
4 guess that's a glowing success of competition to
5 have set down 30 hospitals, and Worcester which
6 was eight hospitals is now two hospitals. That's
7 driving up costs without an assessment of
8 actually health care needs to the public.

9 If we see Quincy Hospital, North Adams
10 Hospital, Jordan Hospital, Milton Hospital, we
11 can't afford to lose these hospitals. And I
12 guess why the debate goes on, including Lawrence,
13 which I agree on some of the issues they're
14 facing. We represent the nurses there.

15 In the meantime, if we can't find a way
16 to hold on to these community hospitals, if any
17 one of those close, we simply have done a
18 disservice because it will drive up costs.

19 MODERATOR TURNBULL: Nancy, you came of
20 age as I did during the time of state health
21 planning. Has the horse left the barn, or is
22 there something that state health planning could
23 contribute to?

24 SPEAKER KANE: Actually, there are some

1 states that are quite a bit less engaged in
2 controlling the rate of increase of new facilities
3 and owners into their health care markets. And
4 I'd say some of them are really suffering for
5 that, particularly the states that have had a lot
6 of venture-backed specialty hospitals like heart
7 hospitals and ortho hospitals.

8 They just come in and siphon off the
9 most profitable patients and leave the community
10 hospitals with less profitable patients. I would
11 say the community hospitals in those markets have
12 shown remarkable resilience in their ability to
13 find other profitable services and raise their
14 prices.

15 So the hospitals survive perhaps, but
16 the affordability of the system doesn't do so
17 well. So I think it is probably, Massachusetts
18 is still relatively more controlling than other
19 states. But I think, you know, since we don't
20 have a -- I'm not aware of a more highly
21 regulated state that does control access more.

22 I can't say that that would be better or
23 worse. Probably some thought going into -- I
24 remember years ago working with the state around

1 St. Margaret's closing. And it served a very
2 useful community purpose. But it just didn't
3 keep up with the, it wasn't competitive on a
4 variety of dimensions. They didn't have the time
5 to keep up by the time they realized they were
6 going down. And I think that probably damaged
7 the community.

8 The next closest option for the types of
9 services they offered was in Brighton, and they
10 were in Dorchester. That's not exactly an easy
11 commute for a teenage pregnant child, girl,
12 person.

13 I think there are a lot of community
14 things that you'd like to have raised. You'd
15 like to have a public conversation about them in
16 some meaningful way. I think that table has been
17 sort of shrunk and removed; and the ideological
18 fervor of government is bad, that probably isn't
19 very thoughtful. And I think we should probably
20 reconsider those removals of constraints of just
21 letting anybody compete anywhere.

22 I do recall the comment of one of our
23 state politicians about when we switched from
24 having a more regulatory all payer certificate of

1 need dominated system to a competitive system,
2 Senator Burke I think it was said let's just put
3 all of these scorpions in the bottle and put on
4 the lid. That's how we lost 30 hospitals.
5 That's how we allowed more expensive hospitals to
6 beat up on the less expensive hospitals. And
7 that' probably has not helped overall our
8 affordability.

9 MODERATOR TURNBULL: A lot of questions
10 from people who are here about global payment. So
11 we've heard a lot I think today, and on Tuesday in
12 particular, about the need to rationalize payment.
13 A couple of speakers on Tuesday talked about the
14 irrationalities in payments regardless of payment
15 method.

16 And one of the things that I found was
17 interesting about the AGO's report was some of
18 the highest paid providers in the state are
19 actually ones who are paid on global payment.
20 And so one of my take-aways from the AG's report
21 is that market leverage trumps payment method.

22 And I think some of these things were a
23 surprise for those of us who don't look at
24 payment things everyday. We heard this morning,

1 we'll pick on two, Atrius and Fallon have the
2 highest health status adjusted total medical cost
3 in their geographical areas.

4 Why isn't this the power of global
5 payment? What's the design flaw, I guess, at the
6 moment in terms of how we're doing this that's
7 causing these integrated globally paid systems to
8 remain so expensive even though they have very
9 strong financial incentives presumably to want to
10 be as low cost as possible?

11 I guess there's a distinction here
12 between being highly paid and being low cost.
13 You're going to get me for it. So I jumped in
14 before. Conversely, what's interesting, is some
15 of the lowest cost systems are paid on a
16 fee-for-service basis.

17 So I guess, what did we learn from these
18 kind of counter-factual things about, as we move
19 forward going towards payment reform?

20 SPEAKER DREYFUS: Do you want me to take
21 that?

22 MODERATOR TURNBULL: You can start.

23 SPEAKER DREYFUS: I think we learned a
24 lot from it. One thing we learned is that the

1 older risk deals that were the subject of the
2 Attorney General's analysis were not particularly
3 useful in slowing the growth of costs or improving
4 quality.

5 They were just a different way of paying
6 that worked for those particular groups. But I
7 think the evidence suggests that they did not
8 have a significant impact. I think it resulted
9 in different organizations of care which may be
10 useful as models for the future. But I think --
11 again, I hope that when the Attorney General
12 takes a fresh look, let's say, a year or two from
13 now when we have more results from our
14 alternative quality contract, they'll see that
15 the rate of growth with those groups within the
16 contract are declining at a time when the
17 fee-for-service rate is increasing and that that
18 will be an important statement about the
19 potential success of this model.

20 Again, I think the reason why it's
21 somewhat counterintuitive going forward is what I
22 suggested to the Assistant Attorney General
23 earlier that we had -- in our own thinking we had
24 to decide how do we entice organizations into a

1 new payment model that actually anticipates their
2 overall trend going down relative to our network
3 as a whole, relative to business as usual?

4 And the only way to do that was to start
5 them close to where they were today. In some of
6 those cases, those were organizations that had
7 higher, had higher prices; in some cases, lower
8 prices.

9 And so it's a new model in that respect.
10 Again, I can't emphasize enough how often we've
11 seen in a very short period of time referral
12 patterns start to change within these
13 organizations. Some of these issues, we hear
14 about Lawrence General, we hear about Winchester,
15 have already begun to change because the
16 physicians understand that if they keep their
17 patients locally that the overall cost of the
18 care will be lower; that it will be more
19 integrated, more seamless, more coordinated for
20 the patient and the system as a whole will
21 benefit.

22 So I'm very optimistic about that.
23 We'll have to see what the results are. We don't
24 necessarily think that our model is the answer.

1 We think it's an answer. We think it's important
2 to try. We've seen this begin to disrupt
3 long-standing relationships in a positive way,
4 and we hope it will start to reverse the trend.

5 SPEAKER LODGE: I just add, since you're
6 starting it, under it, history, and I believe
7 Robert Gannett (phonetics) from Brandeis is here
8 demonstrated that throughout the company global
9 payment and integrated payment systems absolutely
10 reduced overall cost trends. It's really
11 counterintuitive, that a integrated system that is
12 actually primary care driven would be one of the
13 higher cost systems. It doesn't make any sense.

14 Frankly, I've managed groups. I've
15 managed groups under physician groups and
16 hospitals under capitation that have
17 significantly reduced costs. So that even in our
18 beginning parts of this, you can see decisions
19 that are being made that will definitely make a
20 difference in the overall total medical costs
21 that are out there.

22 It's not a perfect system. I'll go back
23 to my advocacy that it's not just about the
24 provider payment. It needs to be a partnership

1 between the products that it designs and the
2 consumers who participate in them that they
3 completely understand what they're getting
4 themselves into.

5 So there is a higher level of compliance
6 rather than just providers being the only force
7 in making this change. But it certainly changed
8 in history, and even the beginning parts of
9 revisiting this seem to be having some early-on
10 successes.

11 It's how it gets supported in the future
12 because the truth is it does need to be more
13 managed, and those primary care physicians need
14 to be given more time to actually manage the
15 care. And rather than living on, I got to see 30
16 patients every single day, I've got to take some
17 time and really think about how I'm going to
18 manage the care of this patient overall. It's a
19 very different animal than a fee-for-service.
20 But it is surprising to see those discrepancies.

21 MODERATOR TURNBULL: Nancy.

22 SPEAKER KANE: I guess the one way I
23 would interpret those discrepancies is that's what
24 the payer negotiated. It's not necessarily their

1 cost structure. So we don't really know if they
2 would have been more or less efficient under a
3 fee-for-service. The other thing about Atrius,
4 I'm less familiar with Fallon, but Atrius
5 contracts have some of the most expensive systems.

6 SPEAKER LODGE: That's also correct.

7 SPEAKER KANE: So it's hard to tell again
8 what the benefits of being integrated on a payment
9 basis when they're still paying out
10 fee-for-service to some of their provider network.
11 But I agree that some of the better integrated
12 systems that have the insurance function merged
13 with the delivery function really are incredibly
14 efficient and much lower cost than other, more
15 fragmented delivery systems.

16 SPEAKER ANDERSON: I'd just like to
17 comment that we don't have an AQC model yet. You
18 heard earlier that we have a relatively low
19 private payer populations at this point. It's
20 something we're interested and we're trying to
21 prepare ourselves for.

22 I have two major issues. One is would
23 it lock in the price disparities that we already
24 have and we're already, clearly have been spelled

1 out? And then also, I think we heard from
2 Dr. Spivak from Mt. Auburn and the other panel,
3 to be effective in these models, you have to be
4 on the right kind of approach to be able to
5 manage it, the right infrastructure, information
6 systems.

7 That in itself takes additional
8 resources that right now as far as our rate
9 structure, all of those factors are not built in

10 MODERATOR TURNBULL: I should probably
11 ask a sort of follow-on question to that which is
12 that and a little bit more. So those of you who
13 were here on Tuesday heard Len Nichols talk about
14 the need for what he called creative antitrust
15 people I think he said as a way to create -- he
16 was talking about it in terms of countervailing
17 market forces to providers with market leverage.

18 One of the things he suggested was with
19 creative antitrusts, people that -- there would
20 be a benefit to the system from a cost standpoint
21 in having payers share information, share payment
22 methods.

23 But you can imagine actually picking up
24 a little bit on what Dianne said that there are

1 tons of areas where if health plans were to
2 collaborate instead of compete with each other,
3 that there could be cost benefits for providers
4 for patients for the market as a whole? And
5 these could range from payment methods to I think
6 helping to collaborate on some of the types of
7 administrative care management investments that
8 need to be made to providers, quality
9 improvement, quality measurement and management.

10 Attorney General Coakley was asked a
11 question after that about whether the Attorney
12 General's Office would be willing to engage in
13 conversations about that. Andrew, I guess, would
14 Blue Cross be willing to do that? Do you see
15 opportunities there? Have you ever tried?

16 You're under oath, so I guess you
17 can't -- I mean --

18 SPEAKER DREYFUS: First of all, I think
19 there's tremendous opportunity, and I think we
20 would welcome the Attorney General's involvement.
21 Even while I'm under oath, I can say for example
22 that in this area of quality measurement that we
23 ought to have a consistent set of measures that
24 the plans use.

1 By the way, I would not just focus
2 simply on the private payers. I think the public
3 payers have an enormous responsibility here.
4 Lawrence General Hospital which has such a high
5 percentage of its patients paid through the
6 Medicaid program, if the Medicaid program moved
7 to a global budgeted payment system, then
8 Lawrence General Hospital would be much more
9 ready to accept global payments from private and
10 commercial payers like Blue Cross.

11 We're also hopeful that our form of
12 local payment would be successful enough in the
13 current market that actual providers will
14 approach the other payers and ask them to pay in
15 this form because it's successful and it's
16 letting them thrive, improve quality, letting
17 them put the primary care patients, the primary
18 care providers back at the center of care where
19 they ought to be. We'd be very open to
20 conversations with the Attorney General's Office
21 about collaboration on a range of issues.

22 MODERATOR TURNBULL: Where do you think
23 there's the most potential to get both long-term
24 and short-term savings? You know, one of the

1 things lots of people point to as a source of
2 rising costs is health plan administrative
3 expenses.

4 Although you pointed out and other
5 people pointed out 90 cents on the dollar, it is
6 still the case, and I'm probably one of the only
7 people in the state who slogged through the
8 financial filings for the plans, that health plan
9 administrative expenses have been going up until
10 the last year or two at pretty much the same rate
11 as medical expenses, you know, far surpassing
12 increases in wages or overall CPI.

13 So you said that Blue Cross has been
14 engaged in a variety of efforts to take costs out
15 of the system? Why are they going up so fast
16 until now? We do want to focus on areas where
17 collaboration could reduce the huge amounts of
18 administrative costs and complexity, not only for
19 health plans but for providers and also medical
20 expenses. Tell me the top couple of areas where
21 we might be able to get some big wins.

22 SPEAKER DREYFUS: I think the big wins
23 are exactly where I thought you were going which
24 is in terms of administrative complexity and

1 simplification. While it's true that 10 percent
2 of the premium dollar supports health
3 administration, we understand that our
4 requirements cause a lot of administrative
5 spending in the delivery system.

6 And if we were to simplify our
7 requirements and/or standardize them across
8 plans, I think it would cause a lot of savings
9 and perhaps, more importantly, cut down a hassle
10 factor; for physician practices especially, but
11 also hospitals, experience.

12 So for example, there is an existing
13 effort where we've centralized credentialing of
14 physicians in a single organization called Health
15 Care Administrative Solutions that actually is
16 housed and supported by Blue Cross, but the other
17 plans participate.

18 I think there may be opportunities to
19 dramatically expand the portfolio of
20 Administrative Solutions that that organization
21 or the health plans together can do. So I think
22 there's a great opportunity there. And I think
23 it would be welcome by the physician and hospital
24 communities that have to hire sometimes an army

1 of staff to deal with competing regulatory and
2 administrative requirements for both health plans
3 and government.

4 MODERATOR TURNBULL: Hospital people,
5 does that sound like that would make a measurable
6 difference?

7 SPEAKER LODGE: I think it would make a
8 world of difference. I'm trying to think, and I
9 was walking in with somebody talking about the
10 number of people that we've had to add to track
11 all the different quality initiatives that are out
12 there right now.

13 It's astronomical. It's not just the
14 people who are doing the data. It's nurses
15 actually who like having doing care having to
16 chase a lot of this data. Let's face reality, if
17 you're going to get paid for it, you're going to
18 make every effort to make sure that you do those
19 things.

20 My advocacy this morning with Barbara is
21 somehow if there could be a collective that came
22 together and said here's the 15 most important
23 quality indicators that you ought to all pursue.
24 Whatever incentives are put into any one of these

1 deals, they're all kind of focused on that. They
2 have the best outcome out there that really
3 standardized it.

4 The products, I don't remember the exact
5 number, thousands of Blue Cross products existed
6 historically. Someone shows up with a Blue Cross
7 card -- basically, it's a Blue Cross card. Who
8 knows what it really represents in the end and
9 just trying to figure all that out, maintain all
10 of that, whether it's at the health plan level or
11 the number of billing people you have in your
12 office trying to chase all of this, there have
13 got to be opportunities there.

14 I'm not saying they're not value added.
15 But in the end, they're not reducing infections.
16 They're not reducing falls. They're not focusing
17 on things that we really are all about in the
18 end. I don't see them as things that distinguish
19 Blue Cross versus Harvard Community Health Plan
20 versus Tufts and not processes that make them
21 something better in the marketplace.

22 So if there's a private, I think Glen
23 Nichols said if you do this private public thing
24 and somehow get around these antitrust laws, it

1 will eliminate some of the hassle factor for a
2 lot of people, you can really streamline a lot of
3 things. I'm very optimistic that something could
4 be done.

5 MODERATOR TURNBULL: Tom.

6 SPEAKER GLYNN: I think I would adjust a
7 couple of things. One on the quality front, I
8 agree with everything that Dale said earlier about
9 the numbers of over 100 different public measures
10 that we're trying to keep track of. In response
11 to what Andrew was saying about administrative
12 complexity, I haven't checked this recently.

13 This was an anecdote that I had
14 discovered a couple of years ago when I was in a
15 discussion with Charlie Baker about
16 administrative simplification. At that time, the
17 Partners billing office had about 450 people
18 sending out bills. Of the 450, 270 were doing
19 rebilling of health plans because the first bill
20 was rejected.

21 Now, you know, we can have an argument
22 about whether or not it was the right number, but
23 that's a big number. Even I would say 270 times
24 an average is a significant amount of expense.

1 In the conversation, Charlie's part of the
2 discussion was to say he had 1,500 different
3 accounts, and virtually each one of them had a
4 different plan because, you know, somebody wants
5 a \$7.50 copay, somebody else wants an \$8 copay.
6 This kind of tailoring, which means he has to
7 keep track, and we have to keep track because
8 when a copay comes in, you have to remember, you
9 know.

10 So there is a big opportunity there. I
11 think there had been some efforts, as Andrew
12 indicated, to try to get ahead of it. More is
13 better. Because it would be a lot easier to try
14 to move some of these other things if people
15 weren't so frustrated with the day-to-day
16 operation of the system.

17 MODERATOR TURNBULL: Mark, I want to ask
18 you, and anybody else who wants to talk about it,
19 a question. And that's about the role of
20 employers as a force for cost control in
21 Massachusetts. Now, we know employers are by far
22 the biggest payers for private health insurance
23 here in the U.S.

24 But in our state, and I think in a way

1 that's a little bit different in many other
2 states, they often seem to be missing in action
3 when we're really talking about cost control.
4 And we have an I think really complex political
5 environment in this dynamic in the state because
6 so many of our largest employers are either
7 providers of care or health plans or biotech
8 firms or pharma firms.

9 In fact, if you look at the boards of
10 the major employer organizations in the state,
11 most of them, not all of them, but most of them
12 have lots of providers on their boards. One of
13 them is chaired by a top official at one of the
14 academic medical centers. One of them was
15 recently chaired by the head of one of the
16 academic medical centers.

17 It's the same thing as the health plans,
18 big employers. On the one hand, this isn't
19 surprising because, I mean, as Tom mentioned, we
20 have very esteemed people in the provider
21 community and business community. There's sort
22 of a level of intersection here because of what
23 our economy looks like. I think it's really
24 quite different than in many other states.

1 It seems to me this actually creates
2 some immense conflicts of interest for employers
3 in terms of thinking that employers will get
4 involved in a robust way in needing to control
5 costs.

6 So I guess I'd love to know from your
7 perspective, do you see this as a hindrance to
8 our ability to control costs? Is there some way
9 to, you know, re-point employers towards cost
10 management? Should we give up because we are
11 just, given the structure of our economy, we're
12 never going to be able to do it? How do we deal
13 with what's to me a huge conflict?

14 SPEAKER GAUNYA: How I respond, I think
15 your characterization of an inherent conflict of
16 interest is absolutely there. It used to be that
17 it was discussions that happened individually, and
18 there wasn't so much crossover between
19 organizations.

20 I think ultimately when you start
21 getting away from policy and start looking at
22 politics, which inevitably happens when you have
23 a conflict of interest, you can't make the tough
24 decisions. Sometimes the tough decisions are

1 painful for everybody.

2 So I go back to the philosophy of
3 transparency again. Do we have a system that's
4 transparent where we know health plan executives
5 are sitting on the Boards of providers, and
6 provider executives are sitting on the boards of
7 health plans? Is that transparent enough for
8 everybody to see for those conflicts of interest?

9 You had us raise our right hand and
10 asked us a second question which is to ask do we
11 have any conflicts of interest with our testimony
12 today? I think if we could again provide
13 transparency at the health plan and provider
14 level of who's serving on whose boards, then
15 perhaps you could have real dialogue about
16 changes that need to be made.

17 As it relates to employers and getting
18 involved in the cost game, my colleagues and I
19 talked to employers. We happen to be the
20 deliverers or, if you will, the messenger of the
21 bad news. I go out every, single day, and I'm
22 talking to employers, CEO's CFO's, HRVP's, and
23 more importantly, the rank and file who
24 ultimately are provided with the insurance

1 product that their companies choose.

2 They're frustrated to no end as to why
3 health care costs rise. But if you get an
4 employer to understand that they are part of the
5 challenge as opposed to the victim and get them
6 engaged in the principles of how we can solve
7 this challenge, which is to say you need to
8 engage your employees in a discussion about
9 transparency of cost and quality, you need to
10 engage your employees in the principle of
11 responsibility, that they have a responsibility
12 to live a healthy lifestyle and to make informed
13 purchasing choices.

14 And just to clarify one point about
15 transparency, nobody's expecting anyone when
16 they're in the hospital bleeding profusely to
17 whip out their laptop and make an educated
18 decision about where they're going.

19 MODERATOR TURNBULL: That's news to me.

20 SPEAKER GAUNYA: But the lion's share of
21 emergency costs are not in those health care
22 areas. There are other things people can be doing
23 about other areas of health care where they can
24 make informed purchasing choices. I don't

1 disagree that it's complicated.

2 But if we can save lives with the
3 technology and know-how we have, I think we could
4 boil down our health care language down to
5 language people can understand. So I reject the
6 notion that it's too complicated. That's frankly
7 the role that people like me play everyday.

8 While the policymakers are doing their
9 things, the providers are doing their thing, the
10 employers look to us to say, okay, here's what I
11 can afford to buy my employees. I want to be on
12 the leading edge so I can attract and retain my
13 employee corporation.

14 I care about my employees, so I want to
15 make sure they have the best available coverage
16 that I can afford to pay for. Now when you work
17 with me to pick out that solution, now I need you
18 to help educate my employees.

19 One of the things you brought up,
20 administrative costs, a few minutes ago, brokers
21 and consultants are often looked at as a source
22 of savings potentially in the system of
23 eliminating us from the equation. I will share
24 with every one of you right now if we are

1 eliminated from the equation, employers would
2 lose their minds.

3 And what do I mean by that? We are the
4 objective source of information of evaluation of
5 all the options. Once an employer picks a health
6 plan, we are also the people responsible for
7 educating their employers. All the while, we're
8 helping employers understand how to stay in
9 compliance with government regulation. And God
10 knows, that continues to grow.

11 So we have a daily effort to keep them
12 in compliance with the law so they don't fall out
13 of compliance. On the health plan side, it's to
14 say, okay, to your point, I have thousands of
15 different options, or maybe hundreds in this
16 case, how do I evaluate what's best for my dollar
17 and give my employees the maximum benefit for the
18 dollar I'm spending? Then once I do it, are they
19 going to understand what it is they have to do?

20 I do think employers can be engaged if
21 they ask the question philosophically where do
22 they sit on that level of I want to engage my
23 employees, or I don't want to engage. If they
24 do, they absolutely can change their cost

1 perspective. If they don't want to, then they
2 won't change it. But I do think going back to
3 the original point of your question that there is
4 inherent conflict.

5 In fact, I was at an advisory council
6 meeting this morning with an unnamed carrier, and
7 it came up, this whole issue of conflict between
8 provider boards and health plan boards and are
9 people not willing to make the difficult
10 decisions because of that inherent conflict?

11 MODERATOR TURNBULL: Anyone else want to
12 respond to that? No. Just one other not entirely
13 related, but somewhat related question. As I've
14 sat here over the last day and a half and as I've
15 kind of watched health care in the state for a
16 long time, but particularly now, there's two
17 conflicting stories about health care's
18 contribution to the economy.

19 In particular, right now as we're
20 talking about costs, we're hearing these tensions
21 come up. One school of thought or argument is
22 that we have to be really cautious about
23 controlling health care costs because health care
24 is the economic engine of the Commonwealth. And

1 we know very predictably one of the things that
2 people will say whenever we talk about
3 controlling costs, and it always comes up with
4 spending controls that it's a job killer bill. I
5 think that has particular resonance now in the
6 economy.

7 The other opposing argument which we
8 heard really eloquently from the Senate
9 President, the Governor and others is that rising
10 medical costs are killing economic growth in the
11 state, killing the job creation. The Senate
12 President said that controlling health care
13 spending is essential to the long-term economic
14 growth of the state. It's also attention that's
15 been playing out for however long national health
16 care reform has been playing out recently.

17 And President Obama has really I think
18 tried to make the economic imperative to control
19 health care costs the central rationale for why
20 we should have national reform. We even heard it
21 on a personal anecdote from Eric Michaelson,
22 owner of Michaelson's Shoes who talked about how
23 he liked to hire another worker, but the cost of
24 his health insurance is making that impossible

1 for him to go.

2 So I find myself sort of not really
3 entirely knowing what to think about this.
4 Nancy, since I often turn to you when I don't
5 know what to think about something complex on the
6 national, is there any research on this? Is
7 there any national data that sort of helps us
8 understand what the impact of rising health care
9 costs and job creation has been on other parts of
10 the economy and the sort of opportunity costs to
11 devoting so many resources to health care in
12 terms of what it's doing to other potential areas
13 of growth?

14 SPEAKER KANE: Obviously, I got a little
15 warning about this question because I brought in
16 an MedPAC study on this topic. Yes, there is some
17 issue about where the jobs in our economy are
18 these days. So MedPAC had done a analysis in
19 their October '08 public presentation that
20 basically showed over the periods 1999 through
21 2008, employment and health care grew five times
22 faster than employment in any other sector of the
23 economy.

24 And I think that when one realizes that

1 all of the other sectors of the economy are
2 required to be able to pay for the sector that's
3 growing, you can create some really
4 cannibalization in a way. If you have to pay --
5 you have to have some people paying premiums in
6 order to employ that many people.

7 You end up destroying jobs in the sector
8 that produces the premium that pays for the job
9 sector that's growing. It sounds a little
10 complicated, but even the health care
11 organizations when you read their financial
12 statements, they often mention that their fastest
13 growing cost is their health premiums and that
14 they've had to raise their rates because their
15 health premiums are going up.

16 So there's obviously pretty close
17 interaction between the fact that health care
18 employment is growing five times faster than any
19 other segment of the economy. We recently
20 updated our employment numbers in our March 2010
21 report to adjust what's happened in the last 24
22 months in the economy where overall employment
23 has dropped over 5 percent over the last 24
24 months; whereas, health sector employment has

1 gone up almost a little over 5 percent.

2 In other words, it seems to be a
3 recession-proof source of jobs. On the other
4 hand, the more that grows, the more you have to
5 have the non-health sector pay for it. And the
6 non-health sector is basically, I think the
7 example by the fellow who owned the shoe store,
8 was a great one.

9 His premiums went up by the same amount
10 of money that he would have otherwise used to
11 hire someone. We eventually get to a point where
12 it's self-defeating. And it's not to say we
13 shouldn't benefit from and foster growth in the
14 health care sector, but I think it's a matter of
15 balance and appreciate the need to keep premiums
16 reflective of value and not some sort of goal of
17 one sector, all employment should happen in the
18 health care sector.

19 MODERATOR TURNBULL: So Tom, you're one
20 of the people --

21 SPEAKER GLYNN: It's possible I might
22 have used that phrase. Again, I don't necessarily
23 think these things are incompatible. Just on the
24 economic engine, you know, Brigham and the MGH are

1 the No. 1 and 2 hospitals in the country with
2 funding from NIH on a competitive basis pretty
3 much year after year.

4 So in the last year because of the
5 stimulus bill, we've gotten over \$200 million of
6 additional funds on top of 7 or \$800 million we'd
7 get every year from NIH. So that is I think an
8 economic engine.

9 However, I think I tried to say, and
10 Mary can probably say it more articulately
11 tomorrow, we are for changing the system. Just
12 because we're an economic engine doesn't mean we
13 shouldn't change the system. We should change
14 the system for all of the reasons that you
15 articulated about, unsustainable levels of
16 increases in cost which Stuart has talked about
17 for many years.

18 The point I was making was if we're
19 going to do something that effects one-sixth of
20 the state's economy, let's make sure it's
21 evidence based. Not let's not change it. Let's
22 change it. But there's a lot of different kind
23 of theories percolating abroad in the land.

24 I think it's important as this exercise

1 has been designed to do to get evidence and get
2 data on the table so we can make an informed
3 judgment as a community, which may or may not be
4 what we would do. At least it's informed and
5 data driven.

6 So I wasn't trying to argue for not
7 changing. I'm for changing. I was just trying
8 to say that we do it as a result of exercises
9 like this where we can get to openly discuss it.

10 MODERATOR TURNBULL: So we're coming
11 towards -- we're at the end of our time. So I
12 just have one more question that I want to ask
13 people. This is a question from someone in the
14 audience.

15 So that there seems to be a lot of
16 agreement, I think this is true, that something
17 needs to be done in this area. And Tom quoted
18 you, Tom said, We may be doing things, but not
19 fast enough. And I think we hear a lot of
20 urgency from the Governor, from the Senate
21 President, from others, and I think from many of
22 you and a lot of people on Tuesday to do
23 something quickly and urgent.

24 So could each of you tell me, we'll just

1 go down, what's the one thing that you think we
2 could do in this area to get results quickly?

3 SPEAKER ANDERSON: Well, I think I can
4 start by saying that I think that there is a real
5 need to pay for value. And if we could do that in
6 a meaningful way that that would make a
7 significant difference for hospitals like ours and
8 physicians in our area and our patients. And that
9 also it would be one step forward in really being
10 able to come up with a lower cost system that
11 still provides high quality for health care
12 reform.

13 SPEAKER DREYFUS: Significantly
14 accelerate payment reform and align that with
15 product and benefit structure.

16 MODERATOR TURNBULL: That was two things.

17 SPEAKER GAUNYA: As it relates to Mass.
18 health care reform, undertake a very quick action
19 to evaluate minimum credible coverage and reduce
20 our standards for minimum credible coverage to
21 allow employers to save money; and therefore, pass
22 that savings onto their employees.

23 MODERATOR TURNBULL: We'll talk about
24 that later, Mark.

1 SPEAKER GAUNYA: I figured you'd
2 appreciate that.

3 SPEAKER GLYNN: 100 percent pay for
4 performance led by the public sector.

5 MODERATOR TURNBULL: So 100 percent
6 meaning what, Tom? All pay related to
7 performance?

8 SPEAKER GLYNN: Yes.

9 MODERATOR TURNBULL: Knowing how quickly
10 the public sector moves?

11 SPEAKER GLYNN: Okay. I didn't say
12 dependent on.

13 SPEAKER LODGE: Develop limited network
14 products immediately and put them in place.

15 MODERATOR TURNBULL: Okay. Julie.

16 SPEAKER PINKHAM: I think I'll just say
17 globally relook at regulations.

18 MODERATOR TURNBULL: Relook at
19 regulations. Okay. Nancy.

20 SPEAKER KANE: I guess we're in the same
21 boat here. I would say reinstall public oversight
22 over the entire pricing and payment system and
23 potentially push that towards an all-payer system
24 that's accountable and transparent to the public.

1 MODERATOR TURNBULL: I think we heard a
2 range of things which are not mutually exclusive
3 which I think goes to the point that Paul Ginsburg
4 made that there are probably solutions which are
5 both regulatory in both markets. So I want to
6 thank you all very much for what I thought was a
7 lively panel and turn it over to Commissioner
8 Morales.

9 COMMISSIONER MORALES: Thank you so much.
10 Before we conclude, I'd like to do two things.
11 The first one is definitely thank the panelists,
12 thank Nancy Turnbull. Thank you all for being
13 here and staying through this, such an important
14 discussion.

15 The second thing I want to do is just as
16 a sit here I jot things down, notes, ask my team
17 to jot important things down. I want to recap
18 some of the things that really stood out for me
19 as I did Tuesday afternoon.

20 The first is Stephen Schoenbaum from the
21 Commonwealth Fund highlighted five key strategies
22 for high performance health systems. While
23 Massachusetts has extended affordable health
24 insurance to all, we still have work to do in the

1 five areas he outlined including aligning
2 financial incentives to enhance value, ensuring
3 care coordination and accessibility, improving
4 quality, improving public/private collaborations
5 and defining clear sets of reform measurement
6 tools.

7 The delivery system panel agreed on
8 several issues, fee-for-service payment
9 structures, incentives inefficiencies in the
10 delivery of care and contribute to higher costs.
11 A number of the panelists pointed to examples
12 where capitation or global payments have made a
13 difference in the outcomes of care.

14 Although limited networks might work to
15 support cost containment, they have historically
16 been difficult to sell to employers and consumers
17 and therefore need to be made more attractive if
18 we should pursue those.

19 There was an agreement that the
20 disclosure of cost and quality information can
21 create the accountability that is needed to
22 create a more efficient system, delivery
23 structure; and the need to strengthen primary
24 care in the Commonwealth was also an important

1 theme.

2 Dr. Ginsburg echoed the need for change
3 in provider payment methods, going beyond just
4 focusing on price. And he reminded us that
5 historically, utilization has been an important
6 cost driver. Dr. Ginsburg cautioned that care
7 should be taken with transparency, particularly
8 on costs which can have unintended consequences
9 and create a race to the top.

10 He suggested that transparency be
11 combined with giving consumers a greater role and
12 incentives to choose efficient providers. When
13 asked about the best options for success,
14 Dr. Ginsburg focused on three issues. Payment
15 reform is the first step toward a more effective
16 and efficient delivery systems. 2., explore
17 consumers incentives and product changes, and 3.,
18 a combination of regulatory changes and market
19 adjustments.

20 From the final panel, we heard arguments
21 against the wide variations in prices paid for
22 the same services delivered by equally qualified
23 providers. It was also recognized that several
24 other factors also contribute to cost such as the

1 aging population and increases in technology,
2 increase in utilization as well as rising prices.

3 The vast amount of information provided
4 here today provided a strong foundation for our
5 shared thinking about how we move forward and
6 next steps for both policymakers and industry
7 leaders.

8 What's clear to me is that the need for
9 action is urgent. We need to do something now.
10 We have to mitigate the health care costs we're
11 seeing. We have to get to a different delivery
12 system of care.

13 An even more in-depth dialogue about
14 specific policy options will take place tomorrow
15 where we will convene for our third and final day
16 of hearings. I'll see you all tomorrow at 9:00
17 a.m. Thank you.

18 (Whereupon, the proceedings concluded at
19 4:35 p.m.)
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22
23
24

C E R T I F I C A T E

COMMONWEALTH OF MASSACHUSETTS
ESSEX, SS.

I, Christine L. Warwick, a Notary Public and
Certified Shorthand Reporter duly commissioned and
qualified in and for the Commonwealth of
Massachusetts, do hereby certify that the
preceding transcript is a true and accurate
transcription of my stenographic notes taken in
the foregoing matter taken to the best of my skill
and ability.

IN WITNESS WHEREOF, I have hereunto set my
hand and Notarial Seal this ninth day of April,
2010.

CHRISTINE L. WARWICK
Notary Public
Certified Shorthand Reporter

My Commission Expires:
May 14, 2010

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Massachusetts Health Care Cost Trends Final Report

Appendix C.5e

Health Care Cost Trends Public Hearings

Transcript for Morning Session Friday, March 19, 2010

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1 **COMMONWEALTH OF MASSACHUSETTS**
2 **DIVISION OF HEALTH CARE FINANCE AND POLICY**

3 **ANNUAL PUBLIC HEARING UNDER**
4 **M.G.L. c.118G, SECTION 6 1/2**
5 **HEALTH CARE PROVIDER AND PAYER COSTS**
6 **AND COST TRENDS**

7
8 **PANEL:**

9 David Morales, Commissioner, Department of Health
10 Care Finance and Policy
11 Thomas O'Brien, Office of the Attorney General
12 Joseph Murphy, Commissioner, Division of Insurance

13 **HELD AT:**

14 University Club, 11th Floor
15 Joseph P. Healey Library
16 University of Massachusetts, Boston
17 100 Morrissey Boulevard
18 Boston, Massachusetts 02125
19 On Friday, March 19, 2010

20 **Morning Session Commencing at 9:00 a.m.**

21
22 **COPLEY COURT REPORTING**
23 **The Mercantile Building**
24 **71 Commercial Street, Suite 700**
 Boston, Massachusetts 02109
 (617) 423-5841

I N D E X**Introductory Remarks:**

David Morales, Commissioner, Division of Health
Care Finance and Policy and Chair of Public
Hearings - Page 3

**Expert Witness: Market Reform Considerations to
Reduce the Growth in Healthcare Spending**

Stuart Altman, Ph.D., Sol C. Chaikin Professor of
National Health Policy, The Heller School for
Social Policy and Management, Brandeis
University - Page 9

Moderator: Alan Weil, J.D., M.P.P., Executive
Director, National Academy for State Health
Policy - Page 8

**Panel: Discussion of Strategies to Mitigate Health
Care Cost Growth**

1) Ralph de la Torre, M.D., President and Chief
Executive Officer, Caritis Christi Health Care -
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2) Deb Enos, President and Chief Executive
Officer, Neighborhood Health Plan - Page 56

3) Gary L. Gottlieb, M.D., M.B.A., President and
Chief Executive Officer, Partners Healthcare -
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4) George Gresham, President, Local 1199 SEIU -
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5) Richard Lopez, M.D., Chief Physician
Executive, Atrius Health - Page 78

6) Dolores Mitchell, Executive Director, Group
Insurance Commission - Page 85

7) Ellen Zane, President and Chief Executive
Officer, Tufts Medical Center - Page 91

Moderator: Alan Weil, J.D., M.P.P., Executive
Director, National Academy for State Health
Policy - Page 51

PROCEEDINGS

COMMISSIONER MORALES: Good morning.

Thank you again for coming this morning as we begin the third and final day of the cost run hearings. First, I'd like to thank my partner in crime here, Assistant Attorney General Thomas O'Brien, who has been diligent and a great partner. I'll be joined soon by Commissioner Murphy, who has also been an extremely helpful partner in this. I want to outline where we've been in the last couple of days and talk a little bit about today's agenda.

As many of you know, Chapter 305 of the Acts of 2008 directed the Division to issue reports on health care costs and to then hold public hearings with key stakeholders of the health care system to help determine the best course of order with action-oriented solutions.

These hearings have a culmination of over a year's worth of researching health care cost growth in Massachusetts by the Division of Health Care Finance and Policy, the Office of the Attorney General, the Commissioner of Insurance and many other key stakeholders.

1 On Tuesday, we heard from experts about
2 the specifics of health care cost growth. We
3 heard alarming facts and need that remind us of
4 the urgency of this problem. We heard from
5 employers and consumers that are grappling with
6 escalating health care costs.

7 Well, there's no question that
8 Massachusetts leads the nation on access to
9 health care. The rapid growth in health
10 insurance costs cuts into peoples' wages, burdens
11 families and hurts our economy.

12 On Thursday, we examined the factors
13 that contribute to high health care costs in
14 Massachusetts including the structure of the
15 health care system and the payment methods
16 currently used by Massachusetts health insurers.

17 We heard about an array of issues
18 ranging from price variation, lack of
19 coordination of care and disparities in the
20 insurance market. We heard common themes from
21 different constituencies, everyone from the
22 leaders of our state's largest hospitals, to
23 those who represent the consumer voice.

24 The problem with health care costs are

1 real. It's urgent and it needs to be addressed
2 soon. It needs to be addressed promptly, but it
3 needs to be addressed with a full understanding
4 of all of the dynamics of our system including
5 the characteristics and the issues that need to
6 be fixed.

7 These hearings have attempted to
8 generate a common understanding of the complex
9 but pressing dilemma we find ourselves in as a
10 Commonwealth. Understanding these factors will
11 better prepare us to evaluate and develop reforms
12 that have the potential to simultaneously contain
13 cost growth and improve our quality.

14 Today with all of the urgency and
15 information on the table, we turn to solutions.
16 We will begin with a presentation of cost
17 mitigation strategies by expert witness, Stuart
18 Altman. Following his testimony, we will hear
19 from a diverse panel to discuss their
20 perspectives on such policy options.

21 The panelists will be sworn in, and will
22 therefore provide their testimony under oath.
23 While the moderator will ask the majority of
24 questions, we at this Panel may intervene at any

1 point.

2 Similar to the past few days, I'd like
3 to encourage you all in attendance to engage with
4 those providing testimony and with the
5 information being shared. Members of my team
6 will pass out index cards. Please, please, I
7 encourage you, please write out your questions.
8 We'll pass them to the moderators. As some of
9 you know, we will engage you in a conversation.

10 In addition, there will be an
11 opportunity for any of you to provide brief
12 comments at 1:00 p.m. where we will open up the
13 microphone for those in attendance who wish to
14 share their testimony or comments. There's a
15 sign-up sheet at the registration table, and I
16 encourage you also to do that. Your insights
17 will help inform the Division's development of
18 the final report to the legislature.

19 Lastly, in addition to the agenda, the
20 acts of the Attorney General led by Tom O'Brien
21 will call Beth Israel Deaconess and Tufts Medical
22 Center at the conclusion of our public comments.
23 Tom O'Brien will ask a series of follow-up
24 questions to that entity.

1 I don't know if, Tom, there's anything
2 else you want to share at this point

3 MR. O'BRIEN: Thank you very much,
4 Commissioner Morales. We appreciate the work that
5 your team has put into these hearings. We have
6 been pleased to participate in this process with
7 you. We have obviously asked a lot of questions
8 to the pre-filed testimony process to payers and
9 providers.

10 We asked supplemental questions to both
11 payers and providers to make sure that the record
12 was complete. And while we've received that
13 supplemental information from a majority of the
14 entities, we still have outstanding information
15 requests from both Tufts Medical Center and from
16 Partners, the Partners System.

17 And until that information is
18 supplemented into the public record, we're going
19 to continue to reserve our rights with regard to
20 these hearings. We do anticipate that that
21 information, based upon our discussions, will be
22 submitted in the very near term; hopefully Tufts
23 Medical Center by the close of business today;
24 and with regards to Partners, the additional

1 information on advertising and marketing that has
2 been omitted to date will also be submitted in
3 the near term.

4 COMMISSIONER MORALES: Great. Thank you.
5 Just as a point of information, every, each and
6 every piece of information that we have submitted
7 to the Division of Health Care Finance and Policy
8 we will and have placed on our website. So if
9 you're interested, there's plenty of information
10 for you to read there. Whatever else is
11 outstanding obviously within bounds will be placed
12 on our website as well.

13 Last point is we will try to end
14 promptly today before five, true and to the form
15 we've kept in the last couple of days. Without
16 further ado, Professor Stuart Altman, you're on.
17 Thank you.

18 MODERATOR WEIL: I've got to get sworn in
19 again, right? Good morning. I think those are
20 the only two words I'm authorized to say before
21 we're sworn in.

22 (Speakers sworn.)

23 **MODERATOR WEIL:** Good morning. My name
24 is Alan Weil. I'm the Executive Director for the

1 National Academy for State Health Policy. We're
2 an independent nonprofit organization dedicated
3 to improving state health problems.

4 While I have no conflicts, I do want to
5 note three connections I have to the
6 Commonwealth. The first is that I lived here for
7 eight years, and my first job after graduate
8 school was that the then Department of Medical
9 Security which no longer exists.

10 The second is that I was the
11 co-principal investigator in the Blue Cross
12 Foundation Program's coverage which led into the
13 enactment of health reform. Third, and probably
14 most important, my middle daughter, Sophia, was
15 born on April 12, 2006, the day Chapter 58 was
16 signed into law.

17 With that, I want to turn over the
18 podium to Stuart Altman, known to all of you, of
19 course, as the Professor of National Health
20 Policy, a tremendous national and state level
21 expertise to begin the discussion today about
22 solutions. Dr. Altman.

23 **SPEAKER ALTMAN:** Thank you. Thank you,
24 Alan. Well, I've had the opportunity to and

1 privilege to testify more than a few times in my
2 career, but I find it much easier to do it when
3 I'm in Washington or in other areas because I can
4 tell them all the crazy things to do, and then I
5 know I can come back to Boston and get good health
6 care and not worry about all these other things I
7 told them to do.

8 But here I am in Boston telling people
9 who control my life what to do. So it's a little
10 bit daunting. And to make matters worse,
11 normally, I'm pretty open-ended about making
12 presentations. But with all the lawyers in the
13 room, if I was ever going to get nervous, this is
14 it. I'm most concerned about Delores sitting in
15 the front row because indirectly she provides the
16 insurance that wraps around my Medicare program,
17 so. With that said, I would be tongue-tied. But
18 I'm going to keep going anyway.

19 I do want to make clear that as I said
20 yesterday for those of you who were here,
21 actually, I have a lot of conflicts of interest.
22 I have so many that I'm purely objective. First
23 of all, I'm very proud to be on the Tufts Medical
24 Center board. I used to be on the Beth Israel

1 board. A lot of my friends are on Partners.

2 I'm very sympathetic to the community
3 hospitals here in Massachusetts. I also sit on a
4 number of insurance boards, none of which are
5 located here in Massachusetts. My career goes
6 all the way back to the early seventies.

7 I was the first regulator for the United
8 States, and I know the benefits of regulation.
9 And I also know the problems of regulation. Stan
10 Wallack and I were both 6'2", 6'4" at the time.
11 Both of us now have been cut down to size. For
12 those of you who have aspirations of being the
13 next regulator, I warn you. I want to make it
14 very clear, I'm falling apart. I care a lot more
15 about the health care system than I did when I
16 was 32 years old.

17 So with that said -- the other thing I
18 want to say, I do spend a lot of my career going
19 around the country and talking about health care.
20 And quite frankly, I'm very proud to be a citizen
21 of the Commonwealth. I think we have an
22 incredible health care system; second to none in
23 this country, if not in the world, both the
24 quality of our hospitals, our health plans, our

1 doctors, you know. I don't care which measure we
2 use in terms of quality. While nothing is
3 perfect, we do have quite a good system.

4 The second thing I want to say is
5 that -- somehow this got out of line. While it
6 is true that the quality is great and it's also
7 true that it spins off a lot of benefits to our
8 society, I mean, I live along 128 as many of you
9 do.

10 And many of the software and tech,
11 biotech companies that are in Cambridge and along
12 128 really move out from our universities and our
13 health systems. So it's fair to say that
14 Massachusetts is a medical mecca. And we should
15 be proud of it, and we should protect it.

16 Nevertheless, I think we've heard over
17 and over again, and I share, we need to be very
18 mindful that there is a problem. And it is a
19 serious problem. And that is that the cost to
20 keep that engine going and moving generates a lot
21 of downside negatives.

22 It generates negatives in terms of
23 individuals and employers and their ability to
24 support the system, and it generates negatives in

1 the loss of jobs outside of the health care
2 system.

3 So we have the benefit of a lot of jobs
4 and high-paying jobs and high-quality jobs in the
5 health system, but we also extract, as we talked
6 about yesterday, a lot of the money that could
7 have gone for more jobs outside.

8 So we have a problem, and we also need
9 to be very mindful that in trying to solve that
10 problem, we don't kill literally the baby with
11 the bath water. So if you find my presentation
12 is in the right direction but maybe not as
13 aggressive, it comes from what I think is
14 balanced trying to deal with it.

15 Now, there's been a lot of talk about
16 the costs and the price of health care, and we
17 got to squeeze down on the prices. We've got to
18 do this. We've got to get this, this is a great
19 curve, and I really want to thank the Attorney
20 General's Office and all of you who did all the
21 work on this. This will live with us for years
22 in terms of explaining.

23 On the other hand, you can spend too
24 much time on it. Because in my view for what

1 it's worth, what we really need to work on is not
2 the current prices that different groups are
3 getting or not getting, but restructuring the
4 delivery system so that we can maintain the
5 quality of care we get, if not improve it while
6 over time we lower care. That's where I'm coming
7 from.

8 Now, so on the delivery system
9 restructuring that, I mean, that's where I come
10 from. But I also know that we will never, ever
11 really redesign the delivery system unless we put
12 in the proper set of financial incentives. You
13 heard yesterday, and I see it all over the
14 country, trust me, I spend -- some of you know me
15 well. When you ask people where I live, I live
16 in 14A on some airplane because I'm around the
17 country; and my life ambition is to be in 2B.

18 And I hear this over and over again from
19 well-meaning hospital administrators, physicians
20 and so on which say I want to do X, but it's
21 financially disadvantaged for me to do it; that
22 basically, if I keep people out of the hospital,
23 if I could do the right thing, I financially lose
24 by doing that.

1 And while I try -- and we mentioned
2 Geisinger in Pennsylvania and Virginia Mason in
3 Seattle, the Mayo Clinic and Cleveland Clinic,
4 and many of our hospitals here and teaching
5 hospitals here in the Boston area as well.

6 So we need to change the payment system.
7 You've heard that over and over again, and I
8 can't emphasize it more. If we don't change the
9 payment system and we try to clamp down on
10 prices, which is what I tried to do in the early
11 1970's -- first of all, it's impossible.

12 Ultimately, the system will overrun you.
13 That's strong advice. You cannot regulate this
14 industry unless you change it. You need the
15 industry to be on your side. And the only way it
16 will be on your side is if we make the incentives
17 working in the same direction that you want.

18 So the question at the heart of it,
19 which is what we talked about over the last
20 couple of days, is how do we get from here,
21 fee-for-service and fragmented care, to where we
22 want to go, which is bundled payments and
23 ultimately integrated care?

24 Now, many of you have heard and written

1 and read about accountable health plans. And I
2 didn't create the term, but I think it's a good
3 term. And really, then the next question is,
4 Well, if you're so smart, what is it? And of
5 course, it's a lot of things. Basically at its
6 heart, it's an organizational structure where the
7 organization takes responsibility for all the
8 care of their patients.

9 They don't necessarily have to provide
10 all the care. You can have an accountable plan,
11 accountable care plan that is a truly integrated
12 system that everything comes out of the same
13 central command. Or you can have one which is a
14 virtual one where groups come together in a kind
15 of like -- they don't get married, they live
16 together. It's kind of like they work together.

17 So how do we get from this fragmented
18 fee-for-service to this integrated care, and as I
19 said, bundled payments? Now, this is a tough
20 issue. I was trained in a very conservative
21 economics department where the market was king.
22 Well, I would have never have gotten my Ph.D. if
23 I didn't believe in it. But then again, I was 26
24 years old, and I wanted to get out.

1 The truth is that the markets have a lot
2 of influence. When markets work well, they work
3 very well. And they are by far our best. I do
4 not believe that given the configuration of our
5 health care system in this current environment we
6 can rely on the market alone to restructure the
7 payment system to get the delivery system to move
8 forward.

9 I want to commend Blue Cross. Blue
10 Cross was the first made -- Blue Cross of
11 Massachusetts was the first major payer in the
12 United States, not just here in Massachusetts, to
13 move forward on a new form of a payment system.
14 They're accountable, their new form of payment on
15 a bundled payment. But alone, it can't do it.
16 It's voluntary. It does not have Medicare and
17 Medicaid under it. It's just, it's not strong
18 enough.

19 That doesn't mean that it's not working.
20 We heard yesterday from Andrew that there were
21 some very good things flowing out of it. But I
22 believe at its heart, we need a more encompassing
23 system. Some people call it all payer. Some
24 people call it other things.

1 A statewide entity -- and by the way, my
2 testimony, I didn't call it anything. It could
3 be commission. It could be a cabal. It could
4 be -- you decide what word you want to use. But
5 the important thing, it has the power of
6 government, state government to help restructure
7 the payment system; and in so doing, restructure
8 the delivery system.

9 Now, some people are sort of thinking
10 ahead. Okay, we're going to do that. How should
11 it be organized? Where should it be? The truth
12 is that if you look around the world or look
13 around the country, you could either be a part of
14 state government; or in many cases, states and
15 the federal government have set up quasi units
16 that have governmental authority, governmental
17 oversight but are independent.

18 Yesterday we talked at some length about
19 MedPAC and ProPAC which I chaired which is an
20 independent entity of this federal government
21 established by an oversight of the federal
22 government, but independent. It brings in
23 experts like Nancy and little people like me to
24 help advise it. And it has a separate staff, and

1 it functions very well.

2 Also, the state of Maryland, which is
3 the only state that still has some form of rate
4 regulation, has a separate entity, separate
5 commission that operates independently. The
6 state has the authority if it chooses to go in
7 and do something, but the ability of the state
8 during the operating charter has limited impact.

9 So you could go either way. That's
10 secondary to the more important thing is the
11 willingness of the state government to do
12 something.

13 Now, here is I know a controversial
14 area. We look at this chart, and we've heard
15 testimony that says that when we look at the
16 differential payment rates, you can't really
17 explain them based on any easily definable index
18 of quality or the complexity of the patients.

19 And I know, I mean, I sit on the Tufts
20 board, and we believe that we provide the best
21 quality care of any institution. And we should
22 be on the top of the list. Alan, you're
23 listening. This is a commercial.

24 And we're not. So there's a tendency to

1 want to change that right away. And I was there
2 too. But in my view, we should keep our eye on
3 the long-term. And that is trying to change in
4 the short run in some, I guess, draconian way,
5 twisting this thing. It sounds good; but in my
6 mind, it would be a mistake.

7 So I in thinking about what I'm
8 suggesting, I would say, okay, let's start from
9 where we are; but let's put the incentives in
10 that move us in the right direction and do it in
11 a way that over time rewards those institutions
12 that provide better quality and other services
13 that we as a community want so that over time if
14 we get my system, if it worked right, you would
15 see a very different chart in maybe five to ten
16 years.

17 Unless the people on the top actually
18 show that not only are they on the top because
19 they're on the top, but because they actually are
20 providing better quality care and more services
21 that we want. By the way, somebody brought up in
22 a question yesterday that I want to repeat, what
23 are we talking about? Are we talking about
24 paying hospitals or institutions just for the

1 care? What about teaching? What about research?
2 And I think those are very important issues.

3 I think as a -- no, I know as a
4 community we need to be mindful that we have
5 certain institutions to take on a greater burden,
6 whether they run a burn center, whether they're
7 more likely to have a high-end ICU or they're
8 more likely to have a trauma center.

9 We need to take that into account when
10 we develop these rates. Once you put the rates
11 in, you can't let just simple brute force win.
12 It has to be based on some internal logic and
13 consistency. With that, so that's where I start.
14 I know some of you will have a different point of
15 view.

16 Now, this isn't going to happen
17 overnight. When I served on the Medicare
18 Commission back in the nineties to redo it, you
19 know, the analogy was made many times that we're
20 talking about an aircraft carrier or a big
21 battleship. You just can't expect it to turn
22 around overnight. Our health care system, 2.5
23 trillion dollars in the country and whatever the
24 trillion, billion dollars in this hearing was

1 developed over a long period of time.

2 So you're not just going to press a
3 button, and it's going to immediately move in a
4 different direction. So we've got to give it
5 time. My suggestion is this new entity be given
6 a five-year limit for the first go-around. Then
7 again, the state government gives it to this
8 entity. The state government retains the right
9 to ask it questions, but I would suggest to the
10 people who represent the state that they leave it
11 alone; and they don't try to sort of micromanage
12 it as it moves forward.

13 Now, as I said, I was a regulator. And
14 in the beginning, it was a very heady experience;
15 but the longer you're in the regulation business,
16 and I've spent a lot of time in Maryland. For
17 six years, I was an advisor to them. It gets
18 very complicated, and it gets very hard to do.

19 So my preference is that if we get the
20 system restructured and it's in the right
21 direction, we can back off the regulatory stuff
22 except for some key issues. As you can see in
23 the proposal that I'm going to put forth, the
24 state needs to establish some form of budget

1 targets for each of the units that we're talking
2 about. And it needs to evaluate the performance
3 of the units relative to the budget. That can
4 never stop.

5 So you can do that without trying to
6 jerry-rig every little piece of the action.
7 Ideally what you want is to set in motion the
8 right set of incentives so our smart people that
9 are running our big institutions and running
10 these new ACO's have the same set of incentives
11 that we want.

12 By the way, I want to deviate for one
13 minute. For those of you who read about these
14 kind of things, there's talk about well there's
15 primary care that should be dominating and so on.
16 You know what, we need a better primary care
17 delivery system. But we have to recognize where
18 we're standing.

19 We have in this state, in this
20 Commonwealth a lot of very good institutions that
21 are big teaching institutions. And they are
22 dominated often by specialists and stuff like
23 that. They can work provided they also have a
24 good primary care. So the idea of whether it was

1 primary care dominated or big institution
2 dominated is less important than they all have
3 the same set of standards.

4 So let me just briefly go through the
5 system, and then we can talk about more
6 questions. Basically, as I said, every payer
7 needs to be in the game, including Medicare and
8 Medicaid. We should not try to do this alone.

9 One of the things we need to do is have
10 the state get a waiver from the government to
11 allow us to function. Basically, the idea, and I
12 want to give credit to Stan Wallack who's here,
13 of Chris Thompkin, basically it's let's start
14 from where we are and allow institutions to fall
15 into one of three tiers.

16 Tier 1 would be fully integrated ACO's.
17 These are institutions that are willing today or
18 in a very short period of time to take full
19 responsibility for the care of all their
20 patients. And they will have either directly
21 under them or contracting with primary care
22 physicians, specialists, hospitals, secondary
23 hospitals, tertiary, so on and so forth.

24 They will get bundled payments for all

1 the care either on an annual basis or at least
2 for a certain set of diseases. And then over
3 time, if they beat that, and there will be a
4 target over time, if they beat the target, they
5 get to keep the difference. If they don't, they
6 get to lose. And in addition, there would be
7 these quality standards and so on.

8 So they're in Tier 1. Tier 2 would be
9 what I call virtual integrated ACO's. These are
10 institutions that don't have complete control
11 over the delivery system but come together so
12 that you could have a teaching hospital. Then
13 you have the primary care. You have specialists.
14 They operate separately, and they each get
15 fee-for-service payments. But there is a central
16 command that works with them to work together.

17 So each of them gets fee-for-service,
18 but the tier, itself, or the group, itself, gets
19 a bundle. And again, if they beat the target,
20 they get to keep it. If they don't beat the
21 target, they don't. And we said, okay, that's
22 Tier 2.

23 There is a Tier 3. There is a group of
24 providers that whether either they're

1 philosophically or emotionally so tied into
2 fee-for-service that they just don't know what to
3 do, they're going to continue to function under
4 fee-for-service. Let them. However, that group
5 in total will be under the same budget target.
6 So if collectively they go off and have 47 MRI's
7 for a bent toe, they're going to pay the price.
8 But you don't force them into two or three. Let
9 them evolve into two or three.

10 So again, quality standards are very
11 important. We have to prevent skimping.
12 Payments have to be adjusted for the health
13 status of enrollees because you wind up with very
14 different. There will be expenditure targets.
15 There will be, as I said, Tier 3 will start from
16 the thing. The hope is that over time we will
17 see a transition from 3 to 2 to 1 as more
18 delivery systems become comfortable.

19 Again, let me end by where I started.
20 We have a very good, high-quality delivery system
21 here in Massachusetts. We want to keep it. But
22 we also realize that over time we need to slow or
23 bend the cost curve because the impact on the
24 rest of our system just is overpowering. So with

1 that. I will stop. Thank you very much

2 MODERATOR WEIL: Thank you, Stuart, for
3 laying out that vision and concrete set of steps
4 to take in the shorter run. Let's start at the
5 long-term vision point and then try to bring
6 ourselves back to what it takes to get there.

7 I want to ask, you raise the role of
8 financial incentives. I want to ask whether
9 there's a difference between what you described
10 as a financial system that supports those who
11 operate in this integrated way and a financial
12 system that pushes people and systems toward that
13 kind of integration if they don't have that
14 desire or leadership already today?

15 In other words, is it the same set of
16 incentives that sustains systems that are doing
17 what we want to do as moved systems to the place
18 that we want them to be?

19 SPEAKER ALTMAN: Well, I think I
20 understand your question, but I may not. Your
21 question is, Is there an interim step between
22 fee-for-service and bundled payments that moves us
23 in that direction?

24 MODERATOR WEIL: Or will bundled payments

1 alone which would clearly support systems that are
2 operating the way you want them to also be the
3 appropriate motivation to move others into that?

4 SPEAKER ALTMAN: Yesterday Paul Ginsburg
5 and I think several of the panelists raised this,
6 and I think they were right. If you just bundled
7 payments but allow the bundles to be as big as the
8 current bundles are, I don't think you're going to
9 get there so fast.

10 Bundled payments are not a panacea.
11 They're not by themselves all you need to do.
12 They're a necessary but not a sufficient
13 condition. I think you need both bundled
14 payments expenditure targets. You need the
15 bundles to be constrained over time.

16 So if we had to take, you know, one step
17 at a time, you know, some people would have the
18 budget targets first. I think the bundles should
19 come first. But ideally what you want is both,
20 the bundled payments and the expenditures.

21 As I said, if the bundles are so big
22 that you can bundle in everything that you're now
23 doing or everything that you conceivably think
24 you're doing, it would have some positive

1 incentive. But it really would limit the
2 constraints in terms of the spending.

3 MODERATOR WEIL: Presumably, those
4 targets need to apply to the rest of the system as
5 well so that those, so that as organizations move
6 into operating in the more integrated way that you
7 suggest they are, they gain something by doing so?

8 SPEAKER ALTMAN: Yeah, right now, I
9 don't mean to speak for the medical community, but
10 right now what they do is they face a whole
11 different set of spigots in terms of money coming
12 in, different ways and different forms. And their
13 job, I mean, that's why they're so good or so well
14 paid or whatever, and that is to try to figure out
15 how to maximize each of the spigots. And they're
16 all different.

17 Medicare in some sense is the biggest
18 problem. I mean, it's a fee-for-service system.
19 It doesn't have any constraints on volume. It
20 has constraints on prices, but not volume. It
21 sets all set of incentives in one direction, and
22 then you have different payers and different
23 forms.

24 So you've got to get Medicare into the

1 game. Yesterday the discussion was also on
2 Medicaid. Medicaid is a big player for certain
3 providers. Now, we can fight about what the
4 right rate is. By the way, when I make -- and I
5 didn't make this clear. Each payer is not going
6 to pay the same amount of money even though
7 everyone should be in the system.

8 You're not going to get Medicaid to pay
9 the same rates as the private. You could make a
10 case that Medicaid ought to pay, you know, maybe
11 more than it is; although, I think Nancy had a
12 good comment yesterday. Medicaid is a state-run
13 program and stuff like that.

14 The delivery system has a responsibility
15 for making up some of the difference. Whether
16 how much is an issue. So every one of the payers
17 needs to be in the game in terms of providing the
18 same set of incentives, but they don't have to
19 start at the same amount.

20 MODERATOR ALTMAN: It's fairly easy to
21 visualize that in a Commonwealth Care organization
22 that's integrated, we have models of them around
23 the country, but I think part of the language of
24 the future is this notion of a virtual ACO or

1 something like that.

2 It rolls off the tongue nicely, but it's
3 a little harder to think about what it looks
4 like. Can you either point us to one or tell us
5 what the elements are so that we would know it
6 when we saw it?

7 SPEAKER ALTMAN: Well, I think you've
8 asked the right question, and I wish I had a good
9 answer for it. You're absolutely right. It's
10 easy to say and hard to do. It's hard to do on a
11 number of levels. I can conceptualize what it
12 looks like. Let's face it, there are very few
13 totally integrated delivery systems in the United
14 States. We talk about Kieser in California.
15 Then you have pieces in Intermountain or Mayo.
16 Partners is very close.

17 I mean, you know, it has a lot of
18 pieces. Whether it has all of them, they're all
19 tied together in the right way, and Tufts has a
20 lot of the pieces too as does the Beth Israel
21 Deaconess.

22 So you know, they're close. They could
23 be Tier 1 if they choose. But most of the
24 delivery systems in Massachusetts, the community

1 hospital, the physician groups, the primary care
2 groups, the specialists still are functioning as
3 units.

4 So what you need as -- but at the same
5 time, they want to work together. You would need
6 a group in the middle, whether it could be one of
7 the pieces that takes on that responsibility or a
8 new piece that is formed that sort of takes
9 responsibility.

10 It goes back to the IPA models in the
11 1970's and 1980's where you had a, it's like a
12 central command that takes the money and then
13 deviates. To sort of prevent some of the
14 problems, if you gave into this one unit, then
15 they would have to divi it out.

16 What we try to do here is allow each of
17 the units that continue to be paid a
18 fee-for-service what they're now getting but
19 recognizing that their ultimate financial gain
20 rests with the ability of each of the units to do
21 the right thing. And that's what this is.

22 MR. O'BRIEN: Just to put it in a
23 different way, for Tier 1, is that by definition a
24 form of managed care product, like a health

1 maintenance organization product? Or could you
2 function with that integration in the PPO
3 structure?

4 SPEAKER ALTMAN: Well, I think the PPO
5 structure would more be 2, but that's on the payer
6 side. This is on the delivery side. But I think
7 your analogy is a good one. The fully integrated
8 HMO that we envisioned back in the early
9 seventies, the Kaiser model is the closest thing
10 to a fully Tier 1 system, where all the pieces are
11 under one roof or under one central authority.

12 And the PPO model, which is someplace
13 between 2 and 3, is a much more loosely
14 affiliated group of providers where in that case
15 the plan maintains the central command. What
16 we're talking about is the delivery system, but
17 it's a good analogy.

18 MR. O'BRIEN: If I could just follow up.
19 Part of it is two things, first off, thank you for
20 not only your comments today but the work on this
21 progress and the work that's being done by the
22 Commonwealth. You mentioned budget targets. Is
23 that a form of reference pricing, or is it
24 budgeted off the existing financial structures?

1 SPEAKER ALTMAN: Well, we're going to
2 start as I said, I mean, my preference, and you
3 can differ about this, would be to allow each of
4 the units to start from where they are. But to
5 say, let's say, that left alone we assume that
6 medical inflation is going to go up by 6 percent,
7 I think the state needs to be very careful. You
8 can't make up numbers.

9 One of the things I didn't say but I
10 want to say very strongly is we have to be
11 realistic at two levels. First of all, we have
12 to realize that most of the pressures on our
13 institutions are not generated internally.
14 They're the federal pressures; how much I have to
15 pay for drugs; how much I have to pay for
16 technology; how the health care system has
17 changed.

18 But with that said, there's no reason
19 why we can't set inflation targets that are a
20 couple of percentage points. And that's an
21 interesting discussion, how low we make those
22 budget targets relative to where we think the
23 system would have gone if we did nothing.

24 MR. O'BRIEN: Just one last follow-up.

1 At least I think it's only one, sorry. If you
2 have these fully integrated Tier 1 structures.

3 SPEAKER ALTMAN: Yes.

4 MR. O'BRIEN: Under the current market, I
5 don't know if there's any dispute that there's a
6 significant amount of subsidization taking place.
7 If you get care in less expensive locations and
8 the risk pooling of insurance, the cost of actual
9 delivery systems is blind to you. There's no
10 incentive to pick one over the other.

11 Obviously, the GIC and others are making
12 strides toward that end. What is the economic
13 argument for having subsidization across Tier 1
14 level accountable care organizations? Stated
15 another way, wouldn't you drive volume to more
16 expensive ACO's if you said here's a less
17 expensive ACO on a total medical expenditure
18 basis, but that you won't pay anything more to go
19 to the more expensive ACO without financial
20 incentives posed to consumers as well as
21 institutions?

22 SPEAKER ALTMAN: I understand where
23 you're going. Let me give maybe not the greatest
24 analogy, and forgive me if I offend anybody by

1 saying that. Let's say we're two people, and one
2 of them is a little heavy, and one of them is a
3 jogger and watches what they eat and does all the
4 right things. Then you say everybody has to lose
5 five pounds.

6 Well, you say the person who's heavier
7 and stuff like that, it's easier for them to lose
8 it because they have extra stuff to begin with.
9 The reality is the people who are well
10 disciplined often do a better job than the ones
11 that aren't.

12 If you have a delivery system that's
13 sitting up on the top that, with all due respect,
14 does not have the discipline to keep their costs
15 under control as opposed to the ones that have
16 been living under a tighter budget and then you
17 impose a budget on both of them and the budget is
18 the same, even though they started out like this,
19 I'm betting that this team knows how to play and
20 over time will do a better job, because they're
21 both facing the same.

22 This team is not going to just be able
23 to make up numbers some would say the way they do
24 now. They're going to have to live under their

1 target. So over time, by and few, these things
2 are going to begin to look like this. Besides --
3 that's the way I hope.

4 Besides, trying to get at this, first of
5 all, if you do it fair and you start coming up
6 with a complexity of how you pay this thing,
7 including all these things like teaching and
8 research and stuff like that, it may turn out
9 that the gap is not as nearly different as you
10 think.

11 There are some that look like that. I
12 understand the argument. Some would say let's
13 take the fat away from here, start like this and
14 then go forward. My preference is to get going.

15 MR. O'BRIEN: Just again, just as a
16 follow-up, it's not suggesting that there's fat in
17 any part of the system. That's not the approach
18 that we took as far as our analysis. It's more a
19 question of whether the incentives to both
20 employers and consumers, wouldn't everybody rather
21 be in 2B than in 14A? If you're driving volume by
22 equalizing the price of it being in front of the
23 plane and the back of the plane, isn't there --

24 SPEAKER ALTMAN: Wait a minute. What we

1 heard yesterday and what we know is that some of
2 them that are not up at the top are providing good
3 quality care, more caring care. You know, what we
4 found and what you found, in fact, you ask that
5 14B looks like 2B. In a lot of variables as a
6 patient, a lot of patients are going to these
7 other institutions, whether it was Winchester or
8 Lawrence or Tufts even though they're not up on
9 the top.

10 So I don't anticipate going forward --
11 one of the things we did here is that if we
12 continue to pay the top ones the top, not only do
13 they have more money to continue to do it, but
14 they also have a way of getting more of the
15 physicians and they're gradually taking a greater
16 percentage of the whole state with them.

17 Over time, they're not going to be able
18 to do that. I understand why there's a feeling
19 to go down quickly. Believe me, if you could
20 figure out a way to do it, I'm not arguing that
21 that doesn't have some merit. But if you keep
22 your eye on the long-term, I wouldn't personally
23 fight that battle. But it's going to be a call
24 that someone has to make.

1 MODERATOR WEIL: I want to bring us as
2 close as we can to the steps to take -- let me ask
3 based on your experience with ProPAC, your
4 reference to Maryland, very hospital-centric rate
5 setting systems. The data, the chart that you
6 kept saying was going to last for years is
7 hospital-centric.

8 We also have, of course, lots of other
9 actors in the system. How much of this attention
10 authority should be focused at the hospital
11 level?

12 SPEAKER ALTMAN: Well, I think you raised
13 a very good point, Alan. First of all, I would
14 not duplicate or replicate the Maryland system for
15 just the reason you gave. It's very
16 hospital-centric. It focuses on inpatient care.
17 It doesn't do a very good job at focusing on
18 outpatient care.

19 I would tell you this. If Maryland laid
20 out its slides, it would look just like this one.
21 Trust me, my friends, and they are my friends at
22 Hopkins, they do okay, thank you. You should
23 hear this community and the rural hospitals in
24 Maryland complain about all the money that's

1 going to Hopkins.

2 Just because you have a regulatory
3 system, don't think you're going to do away with
4 this, nor should you. I mean Maryland is a very
5 proud populace. So A., two things. First of
6 all, I wouldn't do a hospital-centric because of
7 what we learned. And that is so much of an
8 accountable care needs to be out of the hospital.
9 It needs to be.

10 Just because I said in many cases the
11 integrated delivery system is going to be in the
12 central command of a big teaching hospital and
13 given the fact that that's what we are, we're not
14 going to wait. We're not cancers. So we're not
15 going to wake up and say, all right, you know,
16 we're just going to do away with the top 4 or 5
17 teaching hospitals and stick it in some primary
18 care place or whatever.

19 But where that's said, if those top
20 heavy institutions with a lot of specialists
21 don't focus their efforts on primary care,
22 they're never going to hit those budget numbers.
23 By the way, our big teaching institutions, they
24 do have a lot of primary care doctors.

1 It's just a question how they want to
2 use them and whether they want to keep people in
3 the hospital or out of the hospital. I would not
4 do Maryland. You need to change the incentives
5 so it's in their best interests. Don't try to
6 run it from central command.

7 It's in their best interests to keep
8 people out of the hospital, to link up with the
9 community hospitals where they can and to use the
10 specialists in the tertiary care only when they
11 need to.

12 MODERATOR WEIL: When you introduced your
13 three tiers, you talked about the first tier, you
14 used the word institutions where you taking
15 responsibility. Are those provider institutions?
16 Are they insurer institutions? If they're
17 provider institutions, where does the insurer fit
18 in this?

19 SPEAKER ALTMAN: They're primarily
20 providers. And insurers continue to do what they
21 do which is they continue to sell policies. What
22 I didn't talk about, and there was a lot of
23 discussion yesterday, is we need to decide two
24 things. I apologize.

1 One is how you design the insurance
2 packages. One of the things that we danced
3 around yesterday is the role of the patient. And
4 all we did was to say, oh, the patient is
5 wonderful. We got to get the patient into the
6 game. But there's another side of the patient.

7 And for those of you who are patient
8 advocates, patients have to be in the game not
9 necessarily the way they are today. You know,
10 one of the issues that the delivery system people
11 face is patients bopping in and out of the
12 delivery system.

13 If the delivery system has
14 responsibility for budget, but the patients can
15 flip from delivery system A to delivery system B,
16 want all the care, you know, want all the --
17 patients need to have the same set of incentives
18 as the insurers and the delivery system. They
19 need to be concerned about where they go to. And
20 I think that was what Tom was getting at.

21 So the insurers have a role, but the one
22 role that they, that we're taking away from them
23 because, for two reasons, they can't do it
24 because they're not strong enough. And we don't

1 trust them enough because when they did have the
2 strength under managed care, we beat them up.

3 And we said, we don't want insurance
4 companies deciding what our delivery system is
5 like. Now we look at our state. As Nancy
6 pointed out, we got one insurer, 50 percent of
7 the patients. They admitted that they don't have
8 the power to always dictate what the rates are.

9 I think that needs to be a safe
10 responsibility. With that said, the insurers can
11 play the game. They can do a lot of things.
12 They can help these things along. They can
13 facilitate things. There's a lot for the
14 insurers to do

15 MODERATOR WEIL: Then can a provider play
16 in multiple tiers? Or can you --

17 SPEAKER ALTMAN: That's a good question.
18 Theoretically, I think we envisioned or at least I
19 envisioned that providers would be in one of the
20 tiers. They wouldn't be in all three tiers at the
21 same time.

22 That's another thing that broke apart
23 which is when you look at the idea of managed
24 care, a provider would be doing A rather than B.

1 But then everybody would want every doctor and
2 every unit, and the whole thing would break
3 apart. So providers should be in one.

4 FROM THE FLOOR: I'll modify that later,
5 but that's basically true.

6 MODERATOR WEIL: You envisioned growth
7 targets in each tier. Are those growth targets
8 the same by tier, or do we need to put a stronger
9 clamp on Tier 3 because of greater risk of cost
10 growth?

11 SPEAKER ALTMAN: No, I think they should
12 be the same. I think Tier 3 is going to have a
13 hard time because basically no one's in control.
14 They have to have the incentive to do more. And
15 then all of the sudden at the end of the year
16 they're going to wind up, they're spending --
17 their growth is 8 percent, and the target is 5.

18 Then all of the sudden there's going to
19 be a lot of money taken back from them because
20 they don't have any, they don't have any
21 discipline. So I would have the same targets on
22 all of them.

23 MODERATOR WEIL: And given that this is
24 sort of the short-term or middle-term agenda, some

1 of the factors that you envision, accountability,
2 risk adjustment, can we do these quickly enough to
3 integrate them into a short-term strategy? I know
4 there's a long-term agenda around those. If we're
5 going to adopt short-term policies that rely on
6 these kind of techniques, are they ready for prime
7 time?

8 SPEAKER ALTMAN: Well, as you know, well,
9 Alan, we have spent the last 30 years in the
10 research community trying to create risk
11 adjusters, trying to better understand how to do
12 things. Are we there? Are we perfect? No.

13 I mean, we come up with risk adjusters
14 where the problem, you know, the correlation is
15 .3 which is that it's not great. But we are far
16 better prepared today than we were in 1971 when
17 the president and me were running around the
18 country saying every hospital can only raise
19 their prices by 2 percent; and like everyone
20 said, but, but, but, we have sicker patients.

21 And we have no way of knowing. Now we
22 have a DOG system. We're much better today, but
23 we're not perfect.

24 MODERATOR WEIL: I know we're better.

1 But I guess the question is, If you went to the
2 provider community, the payer community and said
3 this is as good as we have, and we're now instead
4 of having this graph where we can't explain it, we
5 are going to basically force it into explaining it
6 by the factors that we do have, are we ready to
7 stand up to the provider system and the public and
8 say this is the right way to do payment?

9 SPEAKER ALTMAN: The reason why I
10 created -- no I created -- our team created what
11 is fairly conservative in terms of changing the
12 system is because we don't know everything. So
13 this gives the providers a lot of choice. They
14 can basically go in one of the three tiers.

15 It does not restructure the thing, the
16 payment because it may turn out that even your
17 measures, as good a job as you did, those indices
18 are far from perfect.

19 So we, this is deliberately designed to
20 recognize that we have limits in terms of our
21 knowledge base. And so I would hope that most
22 providers would look at this and say, hey, this
23 is a reasonable shot. I've got a shot to play.
24 And it's not forcing me to do things either I

1 can't do or are unfair. And yet, I think it
2 moves us in the right direction.

3 MODERATOR WEIL: So Tier 3, your level
4 really is price at the end of the day because you
5 have no volume control in Tier 3 because there's
6 no organizer? So you basically say for cost
7 containment if they're 3, our lever is price.
8 Your hope in Tier 1 your lever is delivery system
9 improvement which is our long-term goal. In the
10 middle, is it both of those? Is it neither of
11 those?

12 SPEAKER ALTMAN: Well, I hope it's both.
13 In the sense that it still has central command.
14 So there is still, the central authority in that
15 group has responsibility for making sure that
16 volume doesn't get out of control, that they're
17 not doing things that don't make sense. It also
18 has some idea of allocating patients.

19 The group has to get together. It's a
20 group-think here, but I think your analysis is
21 absolutely right. The third tier is still the
22 wild west of today. But over time, they're going
23 to realize being in that environment is
24 financially painful. And the hope is that they

1 will figure out a way to move into 2, and then
2 some of the 2's will move into 1.

3 MODERATOR WEIL: Presumably the reason we
4 would not take the Medicare experience as cause
5 for discouragement is because they're politically
6 with the sustainable growth rate, you can go back
7 and renegotiate price after the fact. But we're
8 going to be tough here and say, you just have to
9 live with your 3 percent rate cut because your
10 utilization went up by 8.

11 SPEAKER ALTMAN: Well, you and I know,
12 most people here know what the sustainable growth
13 rate is which is -- with all due respect to the
14 people that created it, it was the wrong rate. It
15 was designed wrong. It wasn't wrong in concept,
16 but it was too tight.

17 Two things I would say in conclusion.
18 The reason why HMO's failed in the nineties to be
19 the panacea that we hoped is they got too tough,
20 that they accepted the low end of the actuarial
21 curve too quickly. And as a result, the delivery
22 system couldn't deal with it, and then it
23 boomeranged against them.

24 The same thing with the sustainable

1 growth rate. If you create a budget target that
2 is unsustainable, the system will fight you to
3 the end. And ultimately, we will fail. So you
4 can't wake up in the morning and say, oh, I think
5 the growth rate ought to be .5 when the rest of
6 the country is going up by 6.

7 It just will create the wrong set of --
8 that sustainable budget needs to be realistically
9 set. Yes, lower. Yes, bending the curve. But
10 not so low that the system can't function.

11 MODERATOR WEIL: So I would just close
12 with a question of, In your assessment of the
13 ability to bring the whole system under this
14 structure that you've described, we've got ERISA
15 plans. We've got Medicare and Medicaid.
16 Admittedly, again, we're talking not levels but
17 rates of change, do you see the plan you've laid
18 out as amenable and acceptable to those payers?

19 SPEAKER ALTMAN: I've been around a long
20 time, and I can guarantee that it won't be. I
21 mean, everyone's going to figure out a way, well,
22 it's not part -- but we've got to get, I don't
23 know what percentage, 70 percent. We don't need
24 to get 100 percent of the payers into the system.

1 But we need to get enough of them into
2 the system that the delivery system people see
3 that the majority of their money is coming from a
4 force as opposed to the current environment where
5 they're always trying to maximize everything.

6 So you know, as I said, I've been around
7 a long time. Any solution that has an aggregated
8 figure attached to it will be fought by some
9 groups. I'm hopeful that Medicare, which is a
10 real part of the problem, will be more flexible
11 going forward and is willing to participate. If
12 Medicare isn't willing to participate, we've got
13 a -- it's hard for us to do this alone.

14 MODERATOR WEIL: Thank you, Dr. Altman.
15 Thank you for a terrific presentation.

16 COMMISSIONER MORALES: Thank you also to
17 Alan Weil for his great job moderating. We're
18 going to take a short two-minute break to organize
19 our panel. We'll come back promptly.

20 (Short recess taken.)

21 COMMISSIONER MORALES: Good morning
22 everyone and welcome back. I want to begin the
23 morning by first acknowledging Attorney General
24 Martha Coakley who is here with us today.

1 ATTY. GENERAL COAKLEY: Good morning.

2 COMMISSIONER MORALES: Without further
3 ado, I want to now introduce our now distinguished
4 panel. First, Alan Weil will now take over.

5 MODERATOR WEIL: Thank you, Commissioner
6 Morales. Again, we begin with --

7 (Speakers sworn.)

8 (Ellen Zane raised hand after swearing
9 and follow-up questions.)

10 **MODERATOR WEIL:** Good morning. Before we
11 turn to the panel, I just want to note how
12 critical these hearings are. As we as a nation
13 move towards a key vote on comprehensive health
14 reform at the national level, it is obvious that
15 we're going to have to, as you've done in
16 Massachusetts, shortly thereafter turn to a
17 discussion about cost, the cost drivers, what can
18 be done to improve the delivery system.

19 Just as the Commonwealth of
20 Massachusetts has led the way in coverage, I
21 think these hearings are a sign of leadership
22 also on the topic of cost. And in that vein of
23 breaking new ground, they're also challenging and
24 difficult but necessary. So a look forward to

1 the presentations and the discussion today.

2 To preserve the time for content, we're
3 dispensing with long introductions. I'm just
4 going to ask the witnesses to go in the order
5 you're seated, to keep an eye on the timekeeper.
6 If you don't, I will. And I'd rather not.

7 Without any additional delay, as you
8 introduce yourself, please state your name and
9 organization. Ralph de la Torre.

10 **SPEAKER DE LA TORRE:** Thank you. Ralph
11 de la Torre. I'm the president and CEO of Caritas
12 Christi. Commissioner and Attorney General, thank
13 you for inviting me and this panel to share some
14 thoughts with you. I think we're at a critical
15 time in society when it comes to health care
16 reform. We all acknowledge currently, especially
17 in Massachusetts, that there's two components of
18 health care reform that need to be addressed,
19 access and cost.

20 I'll talk about quality in a second. I
21 think that we as a state addressed access fairly
22 well. I think that we acknowledged at that
23 moment that we really didn't have a good solution
24 for cost, but we felt there was a morale

1 imperative, a social justice imperative to make
2 sure people all received adequate health care.

3 For that, I think we all as a panel take
4 a hand in applauding the state. Quality, quality
5 is a paramount concern, and to strive for it is
6 something that permeates every one of our
7 organizations. It is probably, most would agree,
8 not the fundamental problem in Massachusetts.
9 It's not necessarily what's broken which leads us
10 to the cost component, one of the reasons we're
11 here.

12 One of fundamental equations that I
13 believe help govern health care is that the cost
14 is equal to a product, a product of a function of
15 access and a function of quality. In other
16 words, if you increase access without changing
17 the underlying methodology by which health care
18 is delivered, it will lead to an increase in
19 cost. It is virtually a linear relationship.

20 The quality relationship is a much more
21 complicated function for a different discussion.
22 So when we look at and we say we need to address
23 the costs while maintaining the access and the
24 quality, how do we change the underlying

1 methodology by which we provide health care?

2 I think many of us have come to agree
3 that the fee-for-service system is broken. It
4 incentivizes the wrong kind of care. I always
5 kid around that if we invented a cure for heart
6 disease, there would be two huge pluses, and one
7 huge plus and one huge minus. The huge plus is
8 people would live longer and live healthier. The
9 huge minus is it would bankrupt most of our
10 institutions overnight.

11 Too much care is delivered to
12 Massachusetts in expensive settings. No one
13 argues that the tertiary, important care
14 structure that exists in Massachusetts is
15 phenomenal and for high-end care needs to exist.
16 That's not the problem.

17 The problem is that too much basic care
18 travels long distances to provide a higher and a
19 more expensive setting. Also, care needs to be
20 preventative. We need to be treating instead of
21 trying to prevent it. Also, we need to get
22 employers and employees united in the way that
23 health care is paid for so that there is a
24 fundamental understanding.

1 And that might lead to the way that
2 premiums are covered. That might lead to the way
3 that networks are chosen. We at Caritas Christi
4 fundamentally believe in an accountable care
5 organization. Many of you do not know it; but in
6 the last two years, we've led a massive internal
7 reorganization to provide just that.

8 Our 1,200 physicians are fully
9 integrated and at risk together with the
10 hospitals. We have created our hospitals' share
11 bottom lines. We're all one entity. We have
12 created an IT platform that by the end of this
13 year will have every, single physician in our
14 network on, being computerized as well as every
15 hospital.

16 We'll have DHR and EMR in all of our
17 institutions. We partnered with all institutions
18 and all 1,200 physicians together. We partnered
19 with 1199 SIU to create a robust training
20 mechanism at a college that we also own without a
21 regular to train our own workforce to fill the
22 needs we have.

23 At the end of this, we put it all
24 together, and we fundamentally shifted the way

1 that we engage our payers. Right now, Caritas
2 Christi, the majority of its commercial product
3 is risk capitated. That's a dramatic deviation
4 from where we were two years ago.

5 If I could encourage everybody here with
6 a few words is that we did it in two years. It
7 can be done. It's not easy. It is hard, but it
8 can be done.

9 MODERATOR WEIL: Thank you.

10 **SPEAKER ENOS:** Good morning, Commissioner
11 Morales. My name is Deborah Enos, and I am the
12 president and CEO of Neighborhood Health Plan. On
13 behalf of Neighborhood Health Plan, thank you for
14 the opportunity to provide testimony as part of
15 the hearings regarding health care provider and
16 payer cost trends; and as part of the panel
17 addressing solutions to mitigate health care cost
18 growth.

19 Neighborhood Health Plan, also known as
20 NHP, is a Massachusetts-based not-for-profit
21 corporation with headquarters located in Boston.
22 NHP is fully licensed by the Massachusetts
23 Division of Insurance as a Health Maintenance
24 Organization and has provided comprehensive

1 services since 1984. NHP serves Medicaid and
2 commercial members, as well as those covered by
3 Commonwealth Care and Commonwealth Choice. NHP
4 is one of the only two health plans in the state
5 that participates in all aspects of coverage
6 expansion under Chapter 58 health care reform.
7 Approximately 85 percent of NHP's membership and
8 related revenue comes from publicly-funded
9 populations.

10 Central to the mission of NHP is to
11 ensure that quality, affordable health care is
12 being delivered to our members, and we strive to
13 provide culturally competent health care and
14 services to low income, underserved and diverse
15 populations that cut across all race, ethnic,
16 gender, age, orientation and disability
17 spectrums.

18 Rising health care costs are a
19 long-standing problem in our nation, and
20 particularly in our Commonwealth. Contrary to
21 much national commentary, the state's health care
22 reform initiative, Chapter 58, did not cause
23 health care costs to increase.

24 However, the unparalleled success

1 Massachusetts has achieved in expanding coverage
2 through this reform has placed a bright spotlight
3 on our existing cost problems. As part of the
4 initiative, it was always intended that cost
5 would be the necessary and subsequent Chapter in
6 our story, Health Care Reform 2. This intention
7 was codified under Chapter 305 of the Acts of
8 2008 which, among other steps, required the
9 hearings that we are having this week.

10 The results of two distinct and separate
11 state-sponsored reports were made public. The
12 first report, sponsored by the Division of Health
13 Care Finance and Policy cited increases in rates
14 charge had by hospitals and other providers as
15 the major reason for rising insurance premiums.
16 A similar report by the state Attorney General's
17 Office concluded that provider rate increases
18 were responsible for rising health care costs and
19 that those increases were driven by the market
20 clout of certain providers, not the level of
21 quality of care they provided.

22 In our state, 90 cents out of every
23 dollar of health insurance premium collected pays
24 for provider-related health care services. This

1 is an aggregate statistic. For some health
2 plans, depending upon their mix of members, that
3 proportion is even higher. Health plans like NHP
4 that serve predominantly public-funded
5 populations, recently report that the proportion
6 of premium spent on these health services is even
7 higher, as much as 95 cents on the dollar.

8 Reversing or even slowing the rise of
9 health care costs is a complex task. Our current
10 predicament did not evolve overnight, and we will
11 not free ourselves from it that quickly either.
12 Comprehensive, structural change is needed
13 throughout our health care system.

14 Last year, I was privileged to be
15 selected to represent the Massachusetts
16 Association of Health Plans on the
17 state-sponsored Special Commission on the Health
18 Care Payment System, more commonly referred to as
19 the Payment Reform Commission. I joined my
20 fellow commissioners in demonstrating unanimous
21 support for the recommendations of the final
22 report that "global payments with adjustments to
23 reward the provision of accessible and high
24 quality care become the predominant form of

1 payment to providers in Massachusetts within a
2 period of five years."

3 This historic vote took place on
4 July 16, 2009. We are now eight months into this
5 five-year period, and it is unclear, at best,
6 what if any progress we have made toward the
7 goal. While we may not be able to predict with
8 absolute certainty the impact of payment reform,
9 we can predict with 100 percent certainty that
10 we'll never get there if we don't start the
11 process.

12 A comprehensive plan for implementing
13 the recommendations of the Payment Reform
14 Commission should be developed as soon as
15 possible. Such plan should include the
16 establishment of a successor entity to oversee
17 the implementation; and the development of clear
18 and measurable performance goals and benchmarks
19 for monitoring the transition and for reducing
20 state per capita health care costs.

21 The work to develop and implement this
22 five-year plan needs to begin immediately, but
23 there is also a number of short-term measures
24 that can serve to reduce health care costs which

1 can be acted upon with more immediacy.

2 One such measure is the legislation
3 filed by Senator Richard Moore and Representative
4 Harriet Stanley and supported by the
5 Massachusetts Association of Health Plan of the
6 Affordable Health Plan.

7 The Affordable Health Plan would provide
8 rate relief to small businesses by limiting
9 provider reimbursement rates, which is the
10 underlying reason for higher insurance rates, as
11 well as health plan profits. The affordable
12 health plan could be brought to market this year,
13 and could yield savings for small businesses of
14 up to 22 percent over current premiums.

15 Another short-term option is greater use
16 of high value, select or limited networks by
17 private and public payers. The unwarranted
18 variation in costs and quality across the
19 provider community is well-known and documented.
20 State regulations and policies, the market power
21 of certain providers, and the lack of
22 transparency of intra-provider contractual
23 arrangements make it difficult to offer select
24 networks based on the quality and efficiency of

1 the doctors and hospitals.

2 Steps that can be taken to alleviate
3 this situation include the easing of current
4 regulations by the Division of Insurance which
5 restricted the ability to promote limited
6 networks, greater transparency regarding
7 intra-provider contractual arrangements,
8 regulations governing billing practices of
9 geographically dispersed provider entities, and
10 the elimination of all or none participation
11 requirements in health plan products imposed by
12 providers.

13 In the commercial insurance space, use
14 of select networks can be encouraged by
15 variations in product design and member financial
16 incentives in the form of copayments, for
17 example. In the publicly-funded health care
18 arena, the use of financial incentives is largely
19 unavailable and not allowed, for good reason
20 given the economic constraints and challenges of
21 its beneficiaries. In this instance, it is
22 imperative that the emphasis on quality, value
23 driven delivery systems be reflected in public
24 policy.

1 There are several additional actions
2 that could be taken in the short-term that would
3 impact the trajectory of health care costs.
4 Those include a moratorium on new mandated
5 benefits, and repealing those that are no longer
6 effective; strengthening of the DON process to
7 include certain outpatient services and
8 ambulatory surgery; support for demonstration
9 initiatives and pilots which focus on achieving
10 the goals of payment reform.

11 Once again, Commissioner Morales, I
12 would like to thank you for the opportunity to be
13 a part of this important hearing process. On
14 behalf of NHP, I look forward to working
15 collaboratively with you, other policy leaders,
16 my health plan colleagues, our providers, members
17 and the business community to insure a
18 sustainable, quality health care delivery system
19 that the residents of Massachusetts so greatly
20 need and deserve.

21 **SPEAKER GOTTLIEB:** Good morning,
22 Commissioner Morales and other members of the
23 panel. My name is Dr. Gary Gottlieb, and I am the
24 president and chief executive officer of Partners

1 Healthcare. Partners Healthcare is a nonprofit
2 organization, employing more than 50,000
3 individuals.

4 I want to thank you for the invitation
5 to participate in this important public
6 conversation. As we open this dialogue on
7 solutions, let us keep our focus on the priority,
8 how best to deliver care to patients, their
9 families and our communities.

10 We want to be a partner in an
11 examination of all possible solutions. Today I
12 am here to offer new ideas and reinforce
13 attributes of others. Our collective mission is
14 to prevent illness, disability and disease and to
15 heal and treat the sick and injured while working
16 to ease pain and find cures.

17 The health care system has evolved over
18 nearly two centuries with emphasis on diagnosis
19 and treatment rather than prevention and ongoing
20 care. Public and private insurance models have
21 been designed to indemnify individuals from
22 catastrophic costs through sharing risk across
23 broad communities of people, with budgets
24 generally established based on historic costs and

1 actuarial underwriting. The paralegal and
2 seemingly unrelated design and pricing of
3 employer-based private insurance and public
4 programs result in unintended risk sharing and
5 cost shifting among payers.

6 Moreover, unfettered fee-for-service
7 payments have rewarded high insensitive care of
8 the seriously ill and the rapid dissemination of
9 advanced technologies. These payments have also
10 created the need to cross-subsidize the
11 under-reimbursed care of people with complex
12 chronic illnesses.

13 Therefore, a narrow analysis of
14 commercial insurance premiums and prices provides
15 modest guidance to a more complex problem.
16 Unlike a retail commodity, prices for individual
17 health care services reflect a complex web of
18 interactions aimed to support the costs of a
19 broad array of services and activities, some of
20 which may not be reimbursed at all.

21 The greatest opportunity for rapid cost
22 reduction is also potentially the most humane,
23 patient and family centered. Analysis of
24 Medicare data shows that 10 percent of

1 beneficiaries account for approximately 70
2 percent of costs.

3 These individuals are severely ill,
4 suffering multiple medical comorbidities, and
5 many are near the end of their lives. A good
6 number are also Medicaid eligible. Social,
7 economic and behavioral challenges often
8 complicate effective medical care and add
9 significant costs. Every employer-based insured
10 population has similar groups.

11 Under the current health care system,
12 care for this population is generally fragmented,
13 addressing immediate and specific demands and
14 circumstances rather than the whole of their
15 personal and family needs. The absence of
16 coordination results in care that is unplanned
17 and reactive. Care is also often inconsistent
18 with best practices, patient centeredness and the
19 most effective use of resources.

20 Therefore, developing and implementing
21 innovative approaches to managing the proper care
22 for this vulnerable patient population is
23 crucial. Even modest improvements will lead to a
24 significant reduction in costs, reducing both

1 commercial and public payments. But even beyond
2 the potential financial impact, we should be
3 doing this because it is the right thing to do.

4 There are several examples of successful
5 programs which should be evaluated and rapidly
6 scaled so that mesh usual improvements and cost
7 savings can accrue in a timely manner. 1., for
8 several years, the state's Senior Care Options
9 program has combined Medicaid and Medicare funds
10 for high risk dual eligible patients to
11 centralize resources to improve care. Through
12 this mechanism, Commonwealth Care alliance has
13 developed a terrific model which has improved the
14 quality of care while accruing significant
15 savings.

16 Massachusetts General Hospital is in the
17 third year of a Medicare demonstration project,
18 which is managing care for 2,500 high risk
19 Medicare patients under a shared savings model.
20 The program has embedded case managers in primary
21 care offices who follow these patients and try to
22 help them solve problems before they become
23 medical emergencies.

24 MGH invested in this and other care

1 coordination infrastructure and agreed to pay for
2 it out of savings achieved by more efficient,
3 effective care of their patients. They have
4 succeeded in both improving care and accruing
5 savings to the Medicare program.

6 The demonstration project has been
7 renewed with expanded enrollment and is rolling
8 out to Brigham & Women's Hospital and North Shore
9 Medical Center. We're currently evaluating
10 whether aspects of this approach could be
11 applicable to a commercial population for
12 implementation more broadly.

13 The prevention and access to care and
14 treatment program, or PACT, is also focused on
15 high-risk patients, but a different population,
16 isolated low income HIV/AIDS patients. Based on
17 the work of Partners in health in Haiti and
18 Rwanda a, the PACT program in Boston employs
19 tightly supervised community health workers to
20 provide and coordinate care for these patients
21 who struggle with their daily care needs and who
22 access the health care system sporadically and
23 expense civil.

24 PACT workers develop strong

1 relationships with patients, accompany them to
2 appointments and provide or arrange for
3 home-based services. The results of this program
4 to date are promising, reduced hospitalizations
5 and reduced overall health expenses based on our
6 experience with 230 patients enrolled for at
7 least one year.

8 In January, in collaboration with
9 Commonwealth Care Alliance and Network Health,
10 the program was expanded to focus on the care of
11 about 1,500 chronically ill people with diabetes
12 and other disorders who have been using the most
13 resources in Network Health's Cambridge and
14 Somerville population.

15 Potential solutions to our collective
16 challenges come in many forms. Some of the
17 programs I have highlighted are either growing or
18 maturing. Here are some ideas that can be
19 implemented more rapidly.

20 Fee-for-service contracts should have a
21 reasonable component of reimbursement connected
22 directly to performance measures tied to
23 outcomes, quality and patient experience.

24 We should examine bundled payments. A

1 single risk adjusted payment would cover the
2 costs of clinically-defined episodes of care,
3 which can be chronic or acute. These payments
4 cover the full range of services needed to treat
5 the patient, including hospitalization, physician
6 services, rehabilitation services and
7 re-admissions for the same condition.

8 Bundled payments create an incentive for
9 hospitals, post acute facilities and physicians
10 to coordinate care, and also provide an
11 opportunity to engage patients more deeply,
12 especially those with chronic conditions.

13 They also require major changes for both
14 providers and insurers. In order to implement
15 bundled payments, insurers and providers need to
16 be able to develop adequate bundled payments, and
17 employers need to consider changes to their
18 benefit designs.

19 An increasing number of bundled payments
20 can serve as a test run for capitation, as these
21 have similar incentives and require cooperation
22 among many providers. Bundled payment strategies
23 could save from \$685 million to \$39.3 billion
24 over ten years.

1 And as a final step, if interim
2 evaluations indicate its feasibility and
3 advisability, the system should consider moving
4 to a gradual broader adoption of global payments.
5 Provider organizations would be paid a fixed
6 risk-adjusted payment that covers all the costs
7 of care for a certain period of time for a
8 population of patients. As with bundled
9 payments, insurers, and providers need to be able
10 to develop adequate global capitation payments
11 and employers need to change their benefit
12 designs.

13 Strategies would also need to be
14 developed for managing risk issues, as insurance
15 risk would be shifted from insurers to providers.
16 Many decisions would need to be made about what
17 level of provider risk is acceptable and what
18 level of reserves need to be held. Providers
19 would need to be able to successfully manage the
20 risk that they hold under capitation, including
21 what care their patients receive, when they
22 receive it, and from whom.

23 Capitation allows for the least amount
24 of patient choice. Therefore, we all would have

1 to prepare the public to accept some limitation
2 of choice in exchange for the quality and cost
3 benefits.

4 Lastly, we must guard against the
5 perverse incentive of capitation to do less, a
6 complete reversal of fee-for-service and no
7 better place for the patient.

8 And as with any new initiatives, we must
9 measure their effects comprehensively. Robust
10 evaluation is critical. In all of these efforts,
11 our main focus needs to be what is best for our
12 patients, how can we help them manage their care
13 effectively and efficiently?

14 I will conclude by saying that none of
15 this work to transform our health care system can
16 be done alone. Just as our health care system
17 developed over time, and just as we all share
18 some responsibility for the continued growth in
19 health care costs, whether it is through how we
20 provide, how we insure, how we purchase, or how
21 we consume health care, we, providers, insurers,
22 employers and consumers, and the government, all
23 share some responsibility for finding solutions.

24 We believe that a shared approach, which

1 will require change and sacrifice from all of us,
2 will be the key to the successful transformation
3 of our health care system into one that focuses
4 on value for the patient, their families and the
5 communities we serve.

6 Again, thank you for inviting me here
7 today. We look forward to continuing this
8 important conversation.

9 **SPEAKER GRESHAM:** Good morning. My name
10 is George Gresham. I'm the President of Local
11 1199 SEIU, United Health Care Workers. I hope
12 that I'm able to be able to be understood and
13 speak clearly today. This morning, I bit my
14 tongue, and I know that's unusual. People don't
15 believe that. They believe everybody bites their
16 tongue. I'd like to get started.

17 Thank you Commissioner Morales for the
18 opportunity to testify on these very important
19 issues. As a union of more than 350,000 health
20 care workers, we provide care in a wide range of
21 settings. Our mission is to improve and expand
22 quality patient care.

23 We also have the capability for adequate
24 funding towards the delivery of that care. As

1 caregivers, we hope to offer a unique perspective
2 in this discussion about strategies and policies
3 to control rising health care costs.

4 Fundamentally, we agree with most other
5 stakeholders that Massachusetts must act now to
6 slow the rapidly rising cost of health care.
7 Also, we must act now to ensure the success of
8 health reform.

9 There are three key barriers faced in
10 Massachusetts as we seek to control health care
11 costs today moving forward. 1, the lack of
12 workforce training and planning; 2, the behavior
13 of insurance companies, particularly with regard
14 to their reserves and rising administrative
15 costs; and 3, a chronic underfunding for
16 providers at the state and federal levels.

17 First we want to address the role of
18 workforce training and containment costs. 1199
19 and its members are committed to continuing to
20 improve our health care system in Massachusetts
21 by the efficiency of care. We are committed to
22 doing this without sacrificing quality of care.

23 We are advocating for a system of
24 wellness to replace the current system of

1 illness. High turnover rates and aging
2 population and the lack of training programs to
3 ensure workforce readiness are causing
4 significant health care workforce shortages.
5 These factors are also adding unnecessary costs
6 to our health care system.

7 Massachusetts must develop a statewide
8 system to identify how our health care workers
9 can deliver more efficient and more
10 cost-effective care. Through comprehensive
11 training programs, we can then shape our
12 workforce to meet those goals. Investing in
13 workforce training and retention programs is a
14 cornerstone in improving quality, health care
15 delivery.

16 I, myself, started out as a rank and
17 file member. And through the 1199 training and
18 upgrading program, I became an MRI technologist.
19 I took classes, and I rose through the ranks. We
20 have many members who have utilized this training
21 and upgrading fund to advance their careers and
22 education to become LPN's, RN's, physician
23 assistants and even medical doctors.

24 1199 is ready to work with the Governor

1 and the Department of Labor and health care
2 providers throughout the state to build the
3 health care workforce of the future. It is
4 urgent that we build a health care workforce
5 ready to tackle the cost and challenges of
6 treating chronic diseases.

7 Current approaches to chronic disease
8 management are major cost drivers and are having
9 negative consequences on the quality of life
10 experienced by our patients. Nationally, we
11 spend 80 percent of our health care dollars on
12 roughly 20 percent of our patients. These are
13 patients living with diabetes, congestive heart
14 failure, high blood pressure and other chronic
15 illnesses.

16 We can lower the overall process of
17 chronic disease and improve patient outcome by
18 allowing patients to remain in or to return to
19 their homes with the help of community health
20 workers. Meanwhile, the reports prepared by the
21 Division and our own experience leaves us with
22 serious questions about the role being played by
23 insurers in the Massachusetts market.

24 During my years at 1199, we have

1 consistently served an aging and sicker
2 population, and we have witnessed many advances
3 in medical technology and an expanded range of
4 services. Expanding medical costs have driven
5 overall health care costs at a higher rate than
6 inflation.

7 However, the question remains
8 unanswered. Why have non-medical administrative
9 costs for insurers been consistently increasing
10 at the same rapid rate? Why are the increases in
11 insurance payments both to our members and for
12 our employers so dramatically based in increases
13 to payments which hospitals receive from these
14 very same insurers?

15 It is worth noting that long-term
16 payment reform will also likely include
17 additional risk shifting, risk shifting from
18 insurers to providers.

19 Insurance has built billions of dollars
20 in reserve from patient premiums. We believe
21 excess insurance reserves should be used to
22 establish a new provider risk pool. Certainly,
23 any new system must protect the financial
24 viability of individual providers and new

1 accountable care organizations.

2 Simultaneously, we must address the
3 crisis of premium costs in the small group
4 market. If insurance cannot meet the need of
5 providing affordable insurance to small
6 businesses, we should consider expanding the role
7 of the Connector in this area.

8 MODERATOR WEIL: If I could ask you to
9 reach your conclusion quickly.

10 SPEAKER GRESHAM: Thank you. Finally,
11 Massachusetts must address the chronic and growing
12 underpayment by Medicaid, Medicare and other
13 public insurers.

14 **SPEAKER LOPEZ:** Good morning,
15 Commissioner Morales. My name is Dr. Richard
16 Lopez, and I am Chief Physician Executive for
17 Atrius Health, an alliance of five multispecialty
18 medical groups that includes Harvard Vanguard
19 Medical Associates.

20 I will be testifying today on behalf of
21 Harvard Vanguard, a not-for-profit 501(c)(3) tax
22 exempt organization providing comprehensive
23 primary and specialty care from 21 locations to
24 nearly a half a million patients in approximately

1 2 million office visits annually. Our 629
2 physicians and their medical teams are dedicated
3 to bringing a broad range of patient-centered,
4 coordinated services to our communities and
5 making it easier for our patients to be healthy.

6 I am honored to be here to discuss
7 strategies to mitigate health care cost growth.
8 We recognize that the rate of growth in health
9 care costs is not sustainable and that resources
10 already in the system must be put to better use
11 to contain costs.

12 Harvard Vanguard takes seriously our
13 responsibility to be a leader in finding ways to
14 be more cost-effective and simultaneously to
15 increase quality for our community.

16 There must be different approaches for
17 containing costs in the long-term and the
18 short-term. Chapter 305, with the establish the
19 of the Payment Reform Commission, recognizes the
20 need for long-term solutions that center on
21 economic models that provide incentives for
22 continuous improvement in both quality and costs.

23 The commission recognized the inherent
24 difficulties with fee-for-service payments that

1 reward increased volume and the associated
2 increases in cost. We must pursue the direction
3 that they recommended to move to global payments
4 with quality incentives.

5 However, we cannot wait the likely five
6 or more years until these important changes can
7 be implemented. We must stem the rise of costs
8 in the next two to three years, and we recognize
9 that the government may need to take a role in
10 making this happen.

11 We believe that the right balance
12 between short and long-term strategies will be
13 found by implementing the short-term strategies
14 that will not derail our longer term goals.
15 Reducing costs is possible and needed, but cannot
16 be done in a way that is drastic and has
17 unanticipated consequences in the longer run.

18 In the long-term, there are two
19 strategies that we believe will be most effective
20 in creating an economic model with the right
21 incentives to drive down costs.

22 Promote global payment to accountable
23 care organizations. We agree with the Payment
24 Reform Commission's recommendation to move to

1 paying accountable care organizations a global
2 payment that is an appropriate amount of funding
3 for the care of a population of patients with
4 incentives for the quality of care delivered.

5 Harvard Vanguard, which is given top
6 scores when quality is independently measured,
7 currently receives global payment for about half
8 of our funding, accepting full risk for the care
9 of our patients, including care provided at
10 hospitals, other specialists and for pharmacy
11 expenses and imaging.

12 Primary care physicians with established
13 relationships with their patients coordinate care
14 to eliminate duplicate testing, to support the
15 patient in receiving care in the most appropriate
16 setting, and to ensure that care is managed
17 across the continuum into the hospital and
18 beyond. We know that global payments can help
19 providers better allocate limited resources
20 toward care that will ensure the best health
21 outcomes.

22 Redesign health plan products to better
23 link choice with cost. Many patients are insured
24 with products that do not require selection of

1 primary care physician and that allow for choice
2 across a network that includes most of the
3 providers in the state. Without a primary care
4 physician, these products result in fragmented
5 care and allow patients inadvertently to select
6 more expensive settings when the same procedure
7 or test might be done elsewhere for less with the
8 same quality.

9 It is critical to ensure that patients
10 are better educated and have more at stake when
11 choosing more expensive venues for care. We
12 believe that we all must participate in sustained
13 efforts to educate employers and patients about
14 the cost of health care and the role that their
15 choices play in increasing costs.

16 We also must work together with payers
17 to structure products that provide more incentive
18 for appropriate care. It should be noted that
19 PPO's are not designed to work with a system of
20 global payments and currently limit Harvard
21 Vanguard's ability to accept predominantly global
22 payments.

23 There are several shorter term
24 strategies that are in line with the

1 Commonwealth's longer term goal of moving to a
2 new economic model for health care and that
3 should be considered to address expeditiously the
4 current level of costs. These short-term
5 strategies focus on ensuring that the right care
6 is provided in the most appropriate and
7 cost-effective setting.

8 Ensure viability of critical and
9 cost-effective hospitals. Hospitals such as the
10 disproportionate share hospitals and some of the
11 community hospitals have developed specific
12 experience and skill in caring for a population
13 of patients with diverse and often very expensive
14 and complex health needs in a cost-effective way.
15 It is critical that these providers are protected
16 in any short-term measures taken by the state to
17 address costs.

18 These providers offer the appropriate
19 venue and alternative to care at higher cost
20 tertiary hospitals. Without the continued
21 viability of these providers, the Commonwealth
22 will be unable to develop low cost accountable
23 care organizations in the longer term.

24 Shift care into high quality lower cost

1 ambulatory settings. Harvard Vanguard is
2 actively moving care into the ambulatory setting.
3 In that way, we will access lower fees for many
4 services and procedures that are not
5 differentiated in quality from care provided in
6 the hospital.

7 However, it would be difficult to move
8 the whole market in this way quickly. We believe
9 that the Division should evaluate establishing
10 the same total rates for selected high volume
11 ambulatory procedures regardless of whether they
12 are performed in an outpatient setting or in a
13 hospital.

14 We agree with the Division's recent
15 reports that wide variations in rates for the
16 same procedures add considerably to overall cost
17 with little or no correlation between quality and
18 patient outcome.

19 Select networks. We believe it is
20 possible to quickly construct select networks
21 consisting of alliances of high quality providers
22 and hospitals that are currently capable of
23 accepting and sharing risk and providing care in
24 global payment environments to patients,

1 employers and other payers that are willing to
2 accept these networks.

3 This approach could accelerate the move
4 toward ACO's and global payment. We believe
5 that, with appropriate benefit design, these
6 products could be offered below the current
7 average prices for unrestricted PPO products or
8 self insured fee-for-service programs.

9 Harvard Vanguard believes that these are
10 among the many possible strategies that we can
11 employ in the Commonwealth to tackle this issue
12 both in the short and long-term. As we continue
13 our own efforts to bring down our costs of care,
14 we remain committed to working with the Division,
15 other state policymakers and our colleagues in
16 the health care industry to examine and implement
17 the right strategies to address rising health
18 care costs.

19 On behalf of Harvard Vanguard, thank you
20 for allowing me to participate today.

21 **SPEAKER MITCHELL:** Over the past ten
22 years, I have often felt like a cross between the
23 Prophet Jeremiah and Chicken Little. Along with
24 a small group, mostly purchasers, we have been

1 talking about cost, while most people in the
2 health policy field were talking about quality
3 measures and wellness and pay for performance and
4 transparency and making patients have "more skin
5 in the game," all of them carefully avoided using
6 the P word. So I welcome these hearings and the
7 reports from the Attorney General's Office and
8 the Division of Health Care Finance and Policy
9 talking frankly about contracts, prices,
10 compensation and even about the uses and misuses
11 of market power.

12 Although insurance companies, whether
13 nonprofit or for profit, are considered fair
14 game, these have not been comfortable topics when
15 applied to physicians and hospitals. I applaud
16 the Governor's initiative, and the Attorney
17 General's report, particularly as they apply to
18 provider contracts, a black box whose contents
19 have been zealously kept hidden from us
20 purchasers, except when the plans ask us to pay
21 for the contents.

22 Last year, the GIC spent \$1.3 billion of
23 taxpayers' money on health care along with
24 another \$250 million in employee premium

1 contributions, and approximately 90 cents of
2 every premium dollar went to pay providers. Just
3 two weeks ago, the commission authorized rate
4 increases of close to 8 percent, or 4.7 percent
5 higher than last year's increase.

6 Last year's increase turned out to be
7 insufficient to cover this year's spikes in
8 utilization and significantly, prices. Facing
9 the grim reality that our FY 10 spending was
10 going to outrun our appropriation at the same
11 time that tax revenues were plummeting, the
12 commission took the painful and rare step of
13 increasing copays and instituting an up-front
14 deductible in the middle of a plan year.

15 I do not recommend this as a way to win
16 friends or to influence people. A lot of people
17 claim that it is the patients that are the
18 problem. Many of us do eat too much, exercise
19 too little, and have a love affair with the
20 latest technology.

21 People still believe that unlimited
22 choice of providers is good, that more treatment
23 is always better, and the most expensive
24 treatment is surely the best, whether or not the

1 evidence suggests otherwise. I would suggest
2 that constant, expensive advertising on TV,
3 radio, billboards and direct mail has helped
4 create these beliefs and fed the demand for more
5 and more intensive utilization.

6 So, what has been tried, what has not
7 worked to control costs. Pay for performance,
8 the GIC has never participated in these widely
9 used programs, believing that, as our budget
10 demonstrates, we are already paying more than
11 enough. Why should be pay more? These programs
12 have had no effect on costs.

13 Disease management and related programs,
14 the studies show similar patterns. The patients
15 may benefit from these programs and the companies
16 that offer them may make money, but for cost
17 control, over time, these programs have not
18 stopped inflation.

19 The Adam Smith option, namely, let the
20 market work its so-called magic, what the
21 Massachusetts market has wrought is
22 consolidation, market domination and wildly
23 different prices for the same services.

24 Transparency, of course we support

1 efforts to bring consumers information about
2 prices and quality, but the effect on costs would
3 appear to be minimal.

4 Whether it is the power of inertia or
5 the complexity of the data, unless regulators or
6 purchasers are prepared to attach serious
7 financial consequences, making patients pay very
8 heavy penalties for choosing more expensive
9 providers, the publication of prices doesn't
10 affect choice in any meaningful way.

11 So what might work? For starters, I
12 hope the legislature will work with the
13 administration to set up a structure for public
14 examination of rates and their underlying
15 contract provisions, including a review of the
16 contracting provisions described in the Attorney
17 General's report.

18 My agency is happy to be part of the
19 solution rather than part of the problem. We
20 have been profiling both physicians and
21 hospitals, for quality and cost for four years
22 now. And we attach admittedly modest financial
23 consequences to the results, while maintaining
24 choice for consumers.

1 This year we are offering limited
2 network options in all three of our largest plans
3 with premiums 20 percent lower than their full
4 choice alternatives, and the most expensive
5 providers are not included in these plans.

6 Our intention is to market these plans,
7 to grow them, and very frankly, to stir up the
8 market and send a very strong message to
9 providers that neither the taxpayers nor the
10 enrollees can afford to sit by and watch costs
11 just go up and up and do nothing about it.
12 Choice has traditionally trumped cost, but maybe
13 it's time to challenge that tradition.

14 We support the special commission on
15 payment reform's goal of ending fee-for-service
16 and substituting a global payment cyst at the
17 point. We have a chance to get a capitated
18 system right this time. And frankly, speaking
19 for myself, not the agency, I personally would
20 support some variant of rate setting, possibly
21 temporary, if we can't get our arms around the
22 cost monster any other way.

23 Massachusetts, with its intellectual
24 fire pour, its history of managed care, its

1 not-for-profit networks, and its commitment to
2 provide affordable care for all its citizens
3 could, once again, show the nation that we know
4 how to do it. All we need is the will to make it
5 happen.

6 **SPEAKER ZANE:** Good morning, and thank
7 you for this opportunity to testify with some of
8 my very august colleagues and for the opportunity
9 to discuss strategies to mitigate health care cost
10 growth.

11 I would first like to commend you,
12 Commissioner Morales, Governor Patrick and the
13 administration officials, the Attorney General
14 and the legislature for recognizing this critical
15 issue and for taking action to address the
16 problems in one of the Commonwealth's most
17 important industries, an industry that creates
18 hundreds of thousands of jobs in the
19 Commonwealth, an industry that is regarded among
20 the nation's finest.

21 I would specifically like to commend you
22 and the Attorney General for the reports you have
23 produced which have very astutely pointed out the
24 areas where we need more scrutiny, transparency

1 and change in our course of action.

2 The AG and DHCFP reports demonstrate how
3 market pricing disparities, consumer behavior,
4 employer demands, health plan practices and
5 government underfunding all play interrelated
6 parts in the cost trends we are experiencing.

7 To address these issues and move forward
8 in a manner that ensures high quality health care
9 for all of our citizens and a strong and vibrant
10 health care industry, I believe we must look into
11 integration, provider care in the most
12 appropriate location, limited network products,
13 government payment.

14 Creating a truly integrated system. I
15 have gained many years of experience learning to
16 integrate doctors, the services they provide and
17 hospitals. And I can tell you, it's not easy.
18 There's no silver bullet and one size doesn't fit
19 all. It certainly doesn't happen overnight.
20 There is a great deal that goes into meeting the
21 goals of better quality, true integration and
22 savings in the long run.

23 I believe there are innate perverse
24 incentives in the current fee-for-service system

1 and that global payments will better align
2 incentives, thus facilitating integration.
3 However, global payments, in and of themselves,
4 will not address the underlying problems.

5 It is very important to understand that
6 a low cost fee-for-service provider will have a
7 much lower cost trend than a high cost globally
8 paid provider. If we bake in the current market
9 inequities, we will have accomplished nothing.

10 **MODERATOR WEIL:** I want to thank the
11 panel for a great way to start this conversation.
12 My job is to keep us focused on what to do about
13 the problem that brings us here today. And so I
14 want to, as I did with Dr. Altman, begin with
15 sort of the long-term and make sure we have a
16 sense of where we want to go and then try to pull
17 back to see what we can do to get us there.

18 Let me just ask a simple question, and a
19 number of you alluded to it. Is there anyone on
20 the panel today who does not endorse at least the
21 broad objectives of the payment changes
22 recommended by the Payment Reform Commission?

23 So I'm going to take by your silence
24 that that's an agreement. Again, I understand

1 there are many details to be worked out. It's an
2 agreement on a vision for where we want to go.

3 Dr. de la Torre, you began by telling us
4 what your organization has done to move in the
5 direction of being ready for that. What I would
6 like to ask you, although it may be the easiest
7 for you and the others, is to tell us what your
8 institution or organization needs to do to be
9 ready for that shift and what specific public
10 policy change you would find most beneficial to
11 preparing yourself for that shift?

12 SPEAKER DE LA TORRE: Okay. So I think,
13 by telling you what we did and we want to do it,
14 we really had to wholesale change the way our
15 physician, our entire contracting network
16 interacted with our hospital system.

17 I mean, we have a fairly large hospital
18 system of 70,000 admissions, 275,000 EE visits,
19 over a million physician encounters a year. So
20 our contracting network expands well into
21 non-employee physicians. The vast majority are
22 non-employed.

23 We had to completely revamp our
24 contracting network to accept risk and dispense

1 risk throughout our system. We have to bring our
2 individual hospitals within that system to accept
3 that risk with the physicians. This conglomerate
4 then had to invest in a tremendous amount of
5 infrastructure, both IT and Manpower
6 infrastructure. It's about case management,
7 referral management. It's all of those things.
8 We had to put those boots on the ground.

9 Then it required massive IT
10 infrastructure. We converted every, single
11 hospital in our system not only to advanced
12 clinicals, but full CPOE. We're completely
13 paperless as of next month.

14 Every one of our hospitals, every one of
15 our physicians we supplemented the cost of their
16 electronic medical records in their offices with
17 the combination of some of payers so that it's
18 basically good for them. That's 1,200 that we're
19 deploying. Then we felt that we needed to go the
20 next step which is tie it altogether.

21 We contracted with Microsoft to come in
22 with this Amalga product and literally tie all of
23 our point of care hospitals, all of our
24 hospitals, all of our physicians together into

1 one massive share database. That's what we
2 needed to do.

3 It required bylaw changes and
4 reorganization of our hospital system. It
5 required a lot of IT, and it required a large
6 management infrastructure

7 MODERATOR WEIL: So what is the public
8 policy role in supporting that shift, if you
9 hadn't gone through it, or sustaining that shift
10 in a new world?

11 SPEAKER DE LA TORRE: I think it's to
12 incentivize it. You need to incentivize the
13 providers and in some cases providing financial
14 means to achieve this. If I were to say -- we
15 talked about limited networks, for example.
16 Limited networks won't do any good if the limited
17 network exists within a structure of a HMO.

18 All you're doing is disbursing your cost
19 savings throughout a network that absorbs those
20 cost savings and just passes it on. You also
21 have to be careful with limited networks not to,
22 quote unquote, bake in cost discrepancies.

23 There is a sad truth which is that if
24 you look at providers, there is a lot of cost

1 discrepancy. There's even a sadder truth. If
2 you map out those cost discrepancies by
3 individual physician providers, i.e., through
4 utilization, you'll find a pretty substantial
5 socioeconomic disparity in Massachusetts.

6 So we have to be careful not to bake
7 those in as we roll this out. Now, when you roll
8 this out, you have to be careful in limited
9 networks that you price them. I think Dolores
10 alluded to the 20 percent savings. The problem
11 is that if you're covering 80 percent as an
12 employer of the cost of whatever program somebody
13 picks, if you save 20 percent, then you're only
14 saving 4 percent difference on the patient.

15 That's all they're getting because
16 you're picking up 80 percent of that 20 percent.
17 That does not create enough of a discrepancy in
18 pricing to make people choose. So let me give
19 you an example.

20 We created a limited network product for
21 your employees. The year before it was percent
22 of premium pricing, and 100 people chose it. We
23 have an HMO that is a limited network. However,
24 we priced it on a defined contribution. To say,

1 okay, we'll give you this one for almost free, it
2 cost employees no deductible, no copay, 6,000
3 members enrolled in one year. It kind of
4 stretched us a little bit, but that's because we
5 were able to set the economics of the program to
6 make people realize what the difference was, and
7 percent of premium doesn't do that.

8 MODERATOR WEIL: So that was a choice you
9 could make without any external policy
10 intervention. I'd like to hear from some others
11 about the steps you need to take to get there and
12 what you need in public policy to make that
13 possible.

14 SPEAKER ENOS: Sure, and I'll start first
15 with the public policy. As I mentioned before,
16 Neighborhood Health Plan has 85 percent of our
17 members and our business publicly-funded. To pick
18 up on the last comments of our colleague, Ellen
19 Zane, I would say the No. 1 public policy issue
20 that is important is the adequate funding for
21 those public populations.

22 We can form select networks. We can do
23 global payments. We can do a variety of things.
24 If the amount of dollars are so inadequate, it

1 really will not work. So that's the No. 1 policy
2 that we need a comprehensive and rational
3 strategy of how we're willing to pay for our
4 public funded programs.

5 Secondly, with respect to the networks,
6 interestingly, Neighborhood Health Plan was
7 founded by the Massachusetts link of committee
8 house members over 20 years ago. So in essence,
9 we, although we have many providers in our
10 network, we were really founded and our purpose
11 which still exists today is to serve a very
12 particular population.

13 So by definition, we operate somewhat
14 with a limited provider network, particularly
15 through primary care between the community health
16 centers and other centers such as Harvard
17 Vanguard. 80 percent of our members get their
18 care, their primary care in those types of
19 settings. So structurally we have that.

20 For us, what we have to do and what we
21 did do is to work with our other sort of provider
22 colleagues with respect to other types of
23 services. It's interesting when we talk limited
24 network and patient choice and patients to have

1 incentives, and I firmly believe in that, but
2 we're faced with an interesting phenomena in that
3 our members tend to live in particular areas, in
4 urban areas of Boston and other cities, and they
5 tend to live in areas that are very much
6 predominantly by teaching facilities.

7 Those are their community hospitals, and
8 they do not have the mechanisms to drive and
9 transport themselves otherwise. So it's
10 imperative upon us, we have to make those
11 arrangements work and work within a reasonable
12 financial sort of considerations. And so there
13 are partnerships.

14 I say for many at this table that we
15 have developed around that. What I would say is
16 the key, really the key issue is the funding.
17 That is the issue that is most important and that
18 woefully inadequate at this point.

19 MODERATOR WEIL: So let me push a little,
20 and I'm going to turn to Ellen Zane on this topic
21 as well. I think it is clear that there's an
22 infrastructure necessary to make a transition.
23 That infrastructure costs money.

24 What's not clear is money will be

1 translated into the infrastructure. How is it
2 that if you get more resources, the Commonwealth
3 can feel confident that those resources are going
4 into the development of this more efficient
5 system as opposed to the kinds of variation that
6 at least many of the folks over the last few days
7 have expressed is not associated with events like
8 that?

9 How can we, how can you convince the
10 policymakers that when, or how could you
11 structure the financial resources that you feel
12 you need to make that transition in a way that
13 they could feel confident they're getting what
14 you're trying to provide?

15 SPEAKER ENOS: Sure. Well, I'll start
16 first as a health plan. In days when we are able
17 to do reasonable financially, part of that is
18 investments in the core primary care network. And
19 there are numerous instances where we have done
20 that throughout the years and worked
21 collaboratively to do that. But the other has to
22 do with the nature of the financial arrangements.

23 And I think what is critical in some
24 form of global payment, be it actual payments or

1 arrangements around budgeted targets, what is
2 critical is that sort of savings that are
3 incurred in other parts of the system are able to
4 be at least partially reinvested with those
5 providers and other entities that are generating
6 savings.

7 So one of the very classic examples has
8 to do with we all talk and lament about
9 unnecessary emergency room utilization. So there
10 are a number of programs and different things
11 that a health plan can do to effect that. But
12 what happens in the absence of a financial
13 structure that loops that together is that the
14 health plan might say if we are to reduce
15 emergency room utilization, but what does that do
16 for the provider who presumably has had some role
17 in that?

18 That's a system on just a microcosm by
19 an arrangement whereby savings that are targeted,
20 sort of emergency room utilization, that there is
21 a mechanism to sort of invest some of that back
22 toward primary care.

23 MODERATOR WEIL: I'm going to push one
24 more time and say I do understand if you generate

1 savings or have revenues, you can reinvest. My
2 question is, How can you be held accountable to
3 the citizens of the Commonwealth that when you
4 have those savings for resources that you will
5 reinvest? That's what I'm looking for. Does that
6 difference make sense to you?

7 SPEAKER ENOS: I think it can. I think
8 it does. In terms of accountability, I think --
9 well, I will say what happens in our example, very
10 clearly, it's very clearly demonstrated in sort of
11 financial reporting so to speak. So if there are
12 dollars, there are reports that follow all
13 providers. There are reports that are generated
14 that we provide to our board.

15 There's many, many hundreds of reports
16 that we provide to different state agencies. And
17 I think it would not be at all difficult to show
18 utilization, cost against budgets, what the
19 actual results were and what happened to those
20 dollars.

21 MODERATOR WEIL: Thank you. I'm going to
22 jump to you to give us a similar set of thoughts
23 about the accountability.

24 SPEAKER ZANE: On your last point, the

1 accountability?

2 MODERATOR WEIL: Yes.

3 SPEAKER ZANE: I don't believe -- I'm
4 going to take a little bit of a different
5 approach. I don't believe the state can
6 promulgate how the albatross dollars are spent. I
7 believe the way we need to look at it is we have a
8 fix we need to do first.

9 We have a very unlevel field here that
10 doesn't correlate to quality and doesn't
11 correlate it to outcomes and doesn't correlate to
12 acuity. We have to fix that by somehow leveling
13 that to some degree somehow. Then we have to
14 provide incentives like bundled payments, like
15 global payments, like latter day capitation and
16 say to providers, you must have certain kinds of
17 outcomes. And you are going to sink or swim
18 relative to your ability to perform.

19 That inherently will give providers the
20 incentive to do the right thing.

21 MODERATOR WEIL: Is that fix a rate fix
22 alone, or is it the state paying for
23 infrastructure?

24 SPEAKER ZANE: I think every payer has to

1 pay for this infrastructure. We all sit and talk
2 about infrastructure. It's kind of a fuzzy term.
3 When you push people and you say, well, what is
4 infrastructure, the typical answer we get is IT.
5 IT is very, very important, but it is not just IT.

6 It is care managers. It's pharmacists.
7 It's actuaries. The infrastructure we need to
8 appropriately not fly blind in a capitated or
9 global payment type world is very extensive. So
10 every payer needs to understand if they want us
11 to be globally capped, they have a responsibility
12 to partially pay for what it's going to cost.

13 MODERATOR WEIL: So is the citizen of the
14 Commonwealth who sees their premiums have gone up,
15 thinks health care costs are too high, the first
16 thing they're going to hear is we're going to
17 spend more money to build an infrastructure for a
18 better payment system?

19 Then the reason we know that money is
20 being well spent as opposed to all the money we
21 put in now which wasn't so well spent is people
22 five years from now people who don't spend the
23 money right aren't going to succeed in the
24 financial system. I have a hard time figuring

1 out how you're going to make that sale.

2 SPEAKER ZANE: We have to be realistic
3 here. We are not going to flip from a
4 fee-for-service system with no infrastructure to
5 any kind of other system that requires
6 infrastructure for that. Five years from now,
7 we're going to be looking at a lot of damage on
8 our path along the way.

9 I think Mike Whitmore did a very good
10 service in the Globe the other day when he wrote
11 his op. ed. piece about really what we're looking
12 at and what it's going to take. So we have the
13 fix we must do first in order to fix the
14 disparities in this market. That should help.

15 But let us be clear. We have to invest
16 as well, or this isn't going to work. And it's
17 going to be a fair amount of theoretical
18 hyperbole.

19 MODERATOR WEIL: Dolores.

20 SPEAKER MITCHELL: I want to remind you
21 of another P word nobody uses these days. It's
22 called planning. There was a day in which all
23 over this country it was tried. I know everybody
24 will say it didn't work. It didn't work; so

1 therefore, we shouldn't do it again.

2 There's also a theory that says if you
3 just do the same thing the last time all over
4 again, have you no right to expect different
5 results. We've learned a lot in the interim.
6 There are some techniques that could be applied.

7 Simply reviving determination of need
8 whose sad history I can recall by itself would
9 have, I think, some perverse incentives because
10 the people who are already there will get
11 advantage. And the people who aren't yet there
12 are going to be told no, you can't have it. So
13 that won't work.

14 But you can structure a determination of
15 need program of some sort in which you can give
16 assistance to communities or to provider groups
17 or to hospitals or to community health centers to
18 get them either bond preference or loans or some
19 other kinds of financial mechanisms to enable
20 them to do the infrastructure kind of things that
21 would be over and above IT.

22 I think there has been absolutely no
23 discussion about that as a possibility, but there
24 are some other things we can do that are low-tech

1 and probably low cost. I mean, we ought to be
2 encouraging greater use of mini clinics. We
3 ought to be using greater, the great capacity we
4 have in registered nurses as primary caregivers.
5 Beginning to happen, but should be accelerated in
6 my view.

7 Something as simple as palliative care
8 and the enhancement of those programs, while it
9 is usually thought of as a quality measure, is
10 also a cost measure. There's a whole menu of
11 things that we can do and should be doing that I
12 think can have an impact on prices.

13 But I think the thing that I kept saying
14 to the Payment Reform Commission that nobody
15 wants to talk about is that unless the size of
16 the pie gets bigger, there are going to be some
17 winners, and then there are also going to be
18 losers. You have to figure out how to do that in
19 a way that is reasonable and fair and not
20 punitive but, in fact, which moves the dollars in
21 slightly different locations.

22 MODERATOR WEIL: So I want to get the
23 three who've not had follow-up comments to
24 relatively quickly give us your answer to what

1 public policy can do to support your transition,
2 your organization, your folks' movement into this
3 new payment model. And then we'll pull back into
4 some more concrete immediate steps.

5 SPEAKER GOTTLIEB: Sure. There are
6 probably three things. One, as Dolores was
7 inferring, really allow creative approaches to
8 redesign the front end of care. Probably the
9 great asset that we have here in the Commonwealth
10 relative to most of our peers are well developed
11 medical homes in community health centers.

12 They provide inadequate capacity
13 relative to the need of the population. They can
14 serve a much broader population than currently
15 the community they're serving, substitution where
16 there are shortages. The ability as I mentioned
17 before in models that we've also been involved
18 with as well as homeless populations, community
19 health workers in teams together with nurses,
20 care managers, and physicians provides an
21 opportunity to substitute for very, very
22 expensive services and really is an immediate
23 pathway.

24 Right now, the payment structures don't

1 really allow for that relative inflexibility.
2 And that would be critical. Second, I think that
3 a real focus is on cost shifting and looking
4 across where costs are and the decisions we've
5 made and the ramifications for them. So if I
6 said to you that I believe that commercial very
7 high rates are paying for other kinds of
8 services, they're paying for other services that
9 are necessarily reimbursed.

10 Particular sensitivity to the notion
11 that people, that we've taken peoples' behavioral
12 health and diminished its importance over the
13 course of probably two decades on the public and
14 private sector side, on the commercial side we're
15 paying less than 2 percent of premium for
16 behavioral health services.

17 At the same time, people still have
18 brains. They still have behavior. The
19 complexity and the most expensive populations of
20 the behavioral health needs are extremely high.
21 We essentially have cross-subsidized about \$42
22 million worth of losses in the largest behavioral
23 health services in the state in order to be able
24 to provide services where others have had to

1 abandon them because they couldn't afford to
2 deliver on their mission.

3 I think the definitions of complexity
4 that need to be used in measurement of payment
5 need to be critically focused. CMI has been a
6 poor predictor for CMS. It hasn't been
7 particularly valuable. In looking at complexity,
8 we need to look across bundles so that we can
9 create payment mechanisms that look at complex
10 populations and pay appropriately across the
11 spectrum of care.

12 When I look in your hospitals, and I was
13 thinking about it when we talked about the tiered
14 networks, about one in seven patients in the MGH,
15 about one in eight patients at the Brigham are
16 transferred from other hospitals. There's some
17 set of complexity, quality or other care that
18 seems to be necessary that we have the standby
19 capacity, perhaps because of our commercial
20 premiums, that we can afford to be able to have
21 to do stuff that would otherwise lose a lot of
22 money or being too expensive to have. Those
23 patients account for, 12 or 13 percent of our
24 patients account for about 40 percent of our

1 mortality, very substantial losses.

2 So the notion of looking specifically at
3 cost shifting, looking at complexity, redefining
4 the front end and going to the accountability
5 issue, forcing us to scale up programs that are
6 very specifically focused on complex populations,
7 the state has the ability to be more creative in
8 a way that Medicaid and Medicare capitations
9 could be aligned in programs like senior care
10 options, to focus on being able to enable rapidly
11 the payment for care managers and for some of the
12 infrastructure where monies are otherwise wasted
13 in the way that we're responding to the
14 incentives as they exist right now.

15 MODERATOR WEIL: Mr. Gresham.

16 SPEAKER GRESHAM: Sure. I think that we,
17 in order for us to really be helpful, we have to
18 be a part of the system. We think that workforce
19 development and training is something that really
20 provides control over the costs of health care and
21 the ability to provide quality and better quality
22 and more efficient health care.

23 Dr. Bailit told me he talked about the
24 fact that we've worked together in developing a

1 training and upgrading program. I think if we
2 want to make sure that health care in the future
3 is provided in the most efficient and yet at the
4 highest level of quality, then I think that has
5 to be a model that is adopted throughout the
6 industry.

7 Part of our problem, we believe that
8 we're a value added organization. But there is
9 obviously a concern when you regulate an
10 organization, and that is you rise the health
11 care costs up. In fact, we have a history
12 throughout the country of helping to, helping
13 institutions that we're a part of to maintain
14 control of health care costs by working together
15 with management and being innovative in how we
16 can work together.

17 I must say in Massachusetts, if you'll
18 excuse the pun, we like to partner with a lot
19 more organizations and bring value added to that.
20 But it begins for us, we can't be helpful on the
21 outside. Our greatest ability to contribute to
22 this, to help institutions to meet the
23 accountability and the standards that we're
24 talking about is when we work together

1 collectively to do that.

2 MODERATOR WEIL: Thank you. And
3 Dr. Lopez.

4 SPEAKER LOPEZ: Yes. Well, there are a
5 lot of, there have been a lot of good ideas. I'm
6 not going to repeat them. I would add a couple of
7 things. One is I think it's important from a
8 public policy point of view to educate patients on
9 the cost of health care. I think this has been to
10 some degree the white elephant that we haven't
11 really addressed in the room.

12 The fact that really since the inception
13 of indebted payments, third-party payments,
14 patients have been divorced and sort of unaware
15 of the impact of their choices and their
16 decisions. I think this almost calls for a sort
17 of public, sort of a public education campaign
18 like we've done before in other settings around
19 washing your hands or don't litter.

20 There are a lot of things where heavy
21 sort of government education and providing
22 information to health consumers about their
23 choices and what is the impact and promoting
24 incentivizing products, insurance products that

1 really incentivize the patient as well as the
2 providers.

3 The other point I would make is around,
4 is around supporting community hospitals which we
5 believe some of them are, many of them are
6 cost-effective. And they, many of them are
7 struggling. And it's a critical part of being
8 able to deliver accessible health care at a low
9 cost.

10 MR. O'BRIEN: A follow-up question to
11 Dr. Lopez. Before I state the question, I also
12 want to be, on behalf of the office, continue to
13 thank everybody who has been part of this process.
14 The providers at this table, each one of whom
15 participated in our examination have been very
16 cooperative. We appreciate that. Dr. Lopez in
17 particular was very kind with his time in trying
18 to understand the system. We appreciate that.

19 To Ellen's questions about the
20 investment that's necessary. Atrius has, in
21 fact, made these investments. It's put in its
22 pre-filed testimony associated with medical
23 management.

24 I'm sure Dr. de la Torre has similar

1 information that has come through the experience
2 of building that network more recently, and you
3 have a more established network of medical
4 management and infrastructure. In the pre-filed
5 testimony, it was actually Dr. Lindsay's
6 submission, said \$8 to \$12 per member per month
7 or 2 to 4 percent of HMO premiums.

8 Is that consistent with your overall
9 investment, or as far as the investments that you
10 do in order to make your infrastructure
11 successful in managing both risk and performance?

12 SPEAKER LOPEZ: I think that 8 to \$12 was
13 based on some readily identifiable cost that we
14 have. So we looked at, you know, case management,
15 our clinical pharmacy program, some of the other
16 managed care programs we have. So I think that's
17 probably a minimum.

18 But in addition, and I think this is
19 clarified subsequently with your office, you
20 know, there are other embedded costs in our
21 program that are a little bit harder to tease
22 out. You know, for instance, we encourage our
23 patients to sign up for our Internet portal so we
24 can communicate with them readily.

1 They receive their lab results
2 immediately as soon as their doctor receives
3 them. There's a cost to doing that. We think
4 it's an efficient way to practice medicine, but
5 we didn't size that out.

6 Another example of costs like that could
7 be the time it takes to rehab some health coaches
8 on some of our sites or the time where our
9 physicians probably see fewer patients per week
10 than most in the community specifically because
11 they spend that time on the phone, coordinating
12 care and so forth.

13 So I would say that's sort of the
14 minimum. And I think it's, I think our costs in
15 terms of managing this is greater than that.

16 MODERATOR WEIL: So I want to focus us a
17 little closer in. This has been a great set of
18 ideas for long-term transformation as well as the
19 cost containment aspect of it. We know from the
20 Attorney General report and the data presented
21 over the last few days that there is focus on
22 price. And I would say it's relatively easy at
23 least to say that we should start with some sort
24 of a regulatory structure to freeze or recalibrate

1 or something like that.

2 We can fight over, you can fight over
3 the details in how that might be structured. But
4 I want to ask the other side of it, which is,
5 where can we use market forces in the current
6 system for short-term savings on the price
7 component? Is there a role here for market
8 forces to bring down price? Who's prepared to
9 make a concrete suggestion for a policy that
10 would yield savings not just through a regulatory
11 approach, one that comes to price?

12 SPEAKER DE LA TORRE: I don't know if
13 this counts as regulatory or not, but I'll just
14 note some ideas as everybody has been talking that
15 come to mind. I speak with this as a system of
16 community hospitals, five of our six hospitals are
17 340B DSH hospitals. We're in the realm as you
18 mentioned earlier.

19 We didn't reinvent the wheel, okay. So
20 I'm going though throw out ideas, not having
21 thought about them much, but they may fly. How
22 about we monitor rates and have the Commission
23 monitor rates that are paid? And when I say
24 monitor rates, you also have to monitor pay for

1 performance because that's the way we shift rates
2 around.

3 So you have to standardize that. But
4 you create a fee, almost a luxury tax of sorts,
5 but a fee for certain high-end rates. Use that
6 fee that's pulled off the high-end rates to give
7 money to the institutions that need
8 infrastructure support. By doing this, you still
9 allow hospitals to gain profit.

10 The way you can gain profit is with a
11 capitated risk methodology. So they're going to
12 make profits by saving money. So that's just one
13 idea that came to mind.

14 COMMISSIONER MORALES: Ralph, could you
15 explain tangibly what that would look like?

16 SPEAKER DE LA TORRE: Again, I haven't
17 thought much about it. You create a system where
18 you say, okay, we need to understand how the
19 payers are paying the providers. We need to look
20 at how pay for performance is, and we should
21 standardize that as a state.

22 We should report infrastructure money.
23 Money that comes through the back door, quote
24 unquote, should be reported. I'm going to make

1 up wild numbers. Let's say every dollar you get
2 over 300 percent of Medicare as a fee, some kind
3 of average schedule taking into account teaching
4 and research and everything else, you pay 25
5 percent into a fund.

6 Anything over 350 percent of Medicare,
7 again, made-up numbers, you pay 50 percent into a
8 fund. You do that methodology, and you propose
9 that on current rates. So that creates a pool of
10 funding that is available for essentially some of
11 these community hospitals that are really capital
12 starved, so that we can begin addressing these
13 issues in communities where it's a lot cheaper

14 MODERATOR WEIL: So I'm -- it's an
15 intriguing idea, but I'm going to push my question
16 which that feels like a source of funding of
17 investment in the long-term system change that
18 we've been talking about.

19 I'm really trying to figure out does the
20 state have any tools in the short run to address
21 what's been identified as the primary source of
22 premium growth that are not rate regulation?

23 SPEAKER DE LA TORRE: How about the
24 Department of Insurance re-up regulation so that

1 accountable care organizations can create limited
2 networks?

3 MODERATOR WEIL: So a limited network
4 approach is one idea. We'll come back to that in
5 a moment. Other suggestions?

6 SPEAKER ZANE: I was going to say,
7 tomorrow we could start limited networks. We
8 could start this tomorrow, and it doesn't require
9 regulation. It basically requires that the market
10 just be incentivized to do it.

11 Someone mentioned on the panel, Dolores,
12 maybe it was you, the role of the consumer in
13 this though. We really have -- there is a
14 responsibility from a public policy standpoint as
15 well as from employers for us to begin to educate
16 consumers about their responsibility.

17 As I often said, consumers believe that
18 they want what they want when they want it, and
19 then they complain when it's not cheaper. There
20 really needs to be an understanding that if we
21 want to save on our premiums, there is a
22 trade-off associated with that.

23 MODERATOR WEIL: Let's go a little bit
24 down the limited network path. I guess I have a

1 few questions about it, and I'm not going to
2 suggest who should answer; although, that won't be
3 a problem. Are we limiting on pricing? Are we
4 limiting on some sort of quality metric? If so,
5 how transparent can that be?

6 Is our goal merely pedagogical? See, we
7 could really pay less, so it's your fault that
8 the health care system costs so much because
9 you're not picking the cheap option? Or are we
10 really going to move cost dollars and give them
11 resources to move in the accountable care
12 direction?

13 I'm trying to figure out -- we heard
14 yesterday with some limitations that we know of
15 that the efforts at these networks to sell these
16 products haven't been overwhelmingly successful.
17 I'm trying to figure out what we think we're
18 going to achieve by doing this; although, I
19 appreciate that it's a non-regulatory way to do
20 that.

21 SPEAKER MITCHELL: Can I comment on that
22 because I'm just starting to this week or this
23 month? What was our thinking in doing that? We
24 are very acutely aware of what all the negatives

1 are, that there will be adverse selection, that
2 the only people who will join them are people who
3 are twelve years old and healthy and run 100 miles
4 a week.

5 And some of that will no doubt happen.
6 But what we found and what we're banking on is
7 that in the other plans that we have that already
8 have such limited networks, Unicare has a
9 Community Choice, it has only one tertiary
10 hospital; and it focuses on community hospitals.
11 And it was an uphill slide.

12 But the fact of the matter is, it has
13 grown every year in enrollment. And there comes
14 a point where people will, in fact, think long
15 and hard about what the premium is compared to
16 whether or not they want full and unlimited
17 choice.

18 And our hope, and for those of you who
19 are running hospitals, my apologies, our hope is
20 that if we can get enrollment up high enough that
21 our payers, and remember, I'm a purchaser, not a
22 payer, that the health plans in going back to
23 negotiate rates next year with their providers
24 will say, excuse me, you're not in our network.

1 And guess why? You cost too much money.

2 And that will increase their leverage.
3 Because I have to say, and again, those of you
4 from health plans, my apologies, but you have not
5 had backbones of steel.

6 I keep saying there's something wrong
7 with this picture. I pay you millions of
8 dollars, and the providers pay you nothing. They
9 take those millions of dollars away. How come
10 you're scared of them, and you don't care what I
11 say or want? There's something wrong with that
12 picture. I am trying to put a little cement in
13 their backbones. That's what I'm trying to do.

14 MODERATOR WEIL: Ms. Enos.

15 SPEAKER ENOS: I'm scared of you,
16 Dolores. You got one. Actually, quite the
17 contrary, dear friend, with the most respect.
18 With respect to limited networks and Ellen's
19 comment that we could start tomorrow, I think we
20 could.

21 There is a piece, and I don't know if
22 you're considering this in the sort of
23 non-regulatory. It has been some of a
24 restrictive positioning with respect to how

1 health plan products are sort of licensed by the
2 Division of Insurance.

3 In order for there to be enough of an
4 incentive for someone to pick the efficient
5 network, so to speak, or a select network, there
6 needs to be the ability to create enough of a
7 differential in terms of that person's
8 out-of-pocket payment, being towards copays,
9 their premium contribution, et cetera. And there
10 have been some sort of roadblocks with that.

11 So that is one thing that would need to
12 be addressed. Hopefully that's not a huge sort
13 of regulatory issue. But it clearly could. The
14 other thing that I think needs to be addressed is
15 something that I referred to in my initial
16 comments with respect to sort of the transparency
17 and understanding of sort an intra-provider
18 contract arrangement.

19 For example, I may have all kinds of
20 information to show me that this particular
21 provider is going to be, have the characteristics
22 to be selected. And I think that is the network
23 I am picking. But because of sort of coverage,
24 because of providers that operate in

1 multi-settings, sometimes often geographically in
2 different locations from where their main
3 location is, in point of fact, you may think that
4 you're contracting with a select value network
5 only to find out that, you know, half of the
6 specialists are really part of another network;
7 and they bill you as though they're part of
8 another network.

9 That clearly has to be addressed to
10 really make this efficient. I do think limited
11 networks could start quickly with that one twist.
12 There has to be flexibility. One of the
13 things -- and Dolores has wonderful health fairs,
14 and all the plans go and talk to perspective
15 members.

16 One of the things that's changing a
17 little bit in our electronic world, but is still
18 true, is how big is your provider directory?
19 Some of them are the size of two Boston phone
20 books. They don't want to look at it. It's just
21 for security that it's that big.

22 The reality is you have one primary
23 health care provider, and you'll use a few
24 specialists; but the concept that it's very easy

1 just for security sake just to have that whole
2 book I think is one we have to reverse. I think
3 that copayment on commercial and getting public,
4 it has to be public policy and the
5 publicly-funded entity.

6 COMMISSIONER MORALES: As some of you
7 know, have you two of the most market-oriented
8 commissioners sitting across of you. I'd love you
9 to drill down more specifically what those
10 incentives are specifically. I want to go into
11 what Dolores talked about. For the insurers, what
12 would those incentives be? For providers, what
13 would those incentives be? I'd like to drill down
14 on what those incentives are.

15 SPEAKER GOTTLIEB: There are two
16 elements. I think clearly limited networks
17 provide an opportunity in order to think through
18 the continuum of care that's available to an
19 individual to try to potentially produce
20 fragmentation in transit.

21 Several issues are pretty critical. One
22 is what's the comprehensiveness of what necessary
23 services are necessary and available. If they
24 are, how is it they're paid for if fragments of

1 services are not part of the network's overall
2 activities?

3 So if we need to maintain the ability to
4 deliver various kinds of things that are
5 expensive or other things that are very, very
6 attractive to adverse populations that are very,
7 very sick, how do we not create that imbalance in
8 terms of the network?

9 COMMISSIONER MORALES: I'm sorry, you
10 mean in terms of product design?

11 SPEAKER GOTTLIEB: Clearly, not everybody
12 has ever -- it's one step closer to what's in an
13 accountable care organization to have those
14 services. If there are parts that exist in a
15 limited network because those are available and
16 those are being subsidized at the moment by other
17 kinds of payments, they would either go away, the
18 market would shun them the way that they have
19 those services in the past, like substance abuse
20 services which adversely virtually disappeared or
21 rehabilitation and in-home services which are very
22 difficult to maintain with the overall cost
23 shifting.

24 Or on the other hand, obviously sick

1 populations will have an affinity to very, very
2 complex services and may be hard to be paid for.
3 Payers then also will try to create barriers.
4 The other is with networks and with any of these
5 products, what's our ability and willingness to
6 limit influx and eflux of patient populations?

7 Any kind of network or overall program
8 is great when there's durability associated with
9 it. So the network, the payer and the purchaser
10 can work with the providers to work on primary,
11 secondary and tertiary prevention, that will
12 mitigate most expensive utilization.

13 When people can leave products on a
14 weekly basis, on a monthly basis or even on a
15 yearly basis, I mean, we hold up Kieser. But
16 Kieser has the largest permanence of its
17 populations in California. People stay for years
18 and years and years.

19 So they can create value in statin care
20 and keeping people on expensive statins for
21 longer periods of time where the trend is in and
22 out that we have right now essentially our
23 accomplishment is focused purely on cost in a
24 very, very narrow way.

1 So we can put the pressure on access
2 which will then cause downward pressure on cost
3 because we have excess capacity of services.
4 People will shun ultimately complex patient
5 populations. So the design is reasonably
6 critical here.

7 SPEAKER MITCHELL: Since he was looking
8 at me --

9 SPEAKER GOTTLIEB: No, no, no. I was
10 looking at you for empathy because I see your
11 tone.

12 SPEAKER MITCHELL: Just one comment. The
13 benefit's identical. We are not cutting, we are
14 not -- it is not limited benefits. It is limiting
15 choice of providers. That makes a huge
16 difference.

17 SPEAKER GOTTLIEB: Absolutely. If you
18 look across those providers and some providers
19 because of the nature of the way that services
20 have been established have a broader array of
21 services limited and excluded from their network,
22 there won't be payment to be able to support
23 those.

24 We've seen that everywhere where

1 everybody's had to limit stuff, and we've skewed
2 an interest where more expensive higher tech
3 services have paid more.

4 COMMISSIONER MORALES: One more
5 follow-up. Is it possible, Dr. De la Torre, to do
6 that in Boston, or for anyone else to do that in
7 Boston given the type of unique health care system
8 we have here specifically in Massachusetts?

9 SPEAKER MITCHELL: No, and to be fair, I
10 have certain advantages that other purchasers
11 don't have. One of the other things you do, and
12 the lady sitting to my left can testify to this
13 because she probably has some scars, is that I
14 beat up on prospective providers to participate at
15 a rate that we can both agree works for her or
16 works for me.

17 And I didn't get what I wanted, and she
18 didn't give as little as she wanted. But that's,
19 you know, as I say because I'm a big purchaser,
20 there's no question but that I have a little bit
21 of something. It's not because I'm so tough.
22 It's because I'm so big. It makes a little bit
23 of a difference.

24 MODERATOR WEIL: So any solution is going

1 to be complex, and we're not going to work through
2 all the details here. I think one of the tests
3 for a successful short-term strategy is that it
4 has to be simple enough that the complexities can
5 be worked through fast enough that people can see
6 something.

7 And so what I'm hearing on the tiering
8 option is, yes, there are definitely some issues
9 to work through. But on the hierarchy of hard to
10 simple and long-term to short-term, it's kind of
11 in the right quadrant as a place to put some
12 effort.

13 But following on Commissioner Morales'
14 little side comment as he began his question,
15 what other -- that was put out as a market-based
16 approach that could make some movement on price.
17 Are there other things like that that you all
18 want to put on the table, again, other than sort
19 of a regulatory approach that would freeze or
20 potentially recalibrate prices in the market?
21 Yes.

22 SPEAKER ZANE: So I'm going to waiver
23 back to my Mass. Hospital Association hat for a
24 minute because as an association, we've chatted

1 about this. What can we do tomorrow kind of
2 orientation. And since small business premiums
3 are so much in front of our minds, one of the
4 thoughts that we've been discussing is a large
5 reinsurance pool, not dissimilar from what Blue
6 Cross and Blue Shield has actually brought
7 forward, thinking that a reinsurance pool for
8 small employers could be helpful in cutting
9 premiums to the small business community.

10 COMMISSIONER MORALES: Ellen, how would
11 we fund that reinsurance pool? How would we make
12 that work.

13 SPEAKER ZANE: Well, that's a detail,
14 David -- now I'm putting back my own hat because
15 I'm going to tell you my own bias. My own bias
16 everyday as health plans go out and seek premiums
17 from employers, inherent in that premium is a risk
18 reserve. Those risk reserves are sitting on the
19 balance sheets of the health plans. That's a
20 fact.

21 And for those of us that take
22 risk-related products, when the risk gets
23 transferred to us, the health plan then knows
24 their cost, but we don't. But they keep the risk

1 reserve. There are years of compounded effect of
2 risk reserves sitting on their balance sheets.
3 They're collecting them now, and we should have a
4 conversation about that.

5 MR. O'BRIEN: If I could just follow up.
6 I actually heard two different types of
7 reinsurance from your answer. One might be more
8 along the lines of what Dr. de la Torre talked
9 about which is as risk shifts to providers in the
10 payment structure whether there should be an all
11 provider reinsurance pool of some kind so it's not
12 every tub in its own bottom as far as risk, and
13 maybe you need some opportunities to true up the
14 system by having both -- because of the population
15 being served and the cost of those as far as the
16 payment.

17 Separate from what I also heard which is
18 a reinsurance pool to effectively moderate the
19 overall costs of insurance rates within the small
20 group market, are there two there?

21 SPEAKER ZANE: There are two. I cannot
22 speak to a reinsurance pool for all providers
23 because I'm not an actuary. And I don't know what
24 I don't know about the downstream ramification of

1 that. Theoretically, it's interesting. But I'm
2 not sure how that would work. Relative to small
3 business, however, that's the one I was
4 addressing.

5 MODERATOR WEIL: So presumably in order
6 for that reinsurance pool to achieve the goal you
7 had for it, the rate regulation on the insurance
8 side is going to have to be with sufficiently
9 tough scrutiny to measure what kinds of reserves
10 are necessary. And say because your risk profile
11 has gone down due to this pool, your reserves are
12 going to have to go down, and that has to go back?

13 SPEAKER ZANE: Correct.

14 MODERATOR WEIL: Without that, you're
15 just moving money from one pot to another?

16 SPEAKER ZANE: Correct.

17 SPEAKER GOTTLIEB: The question is
18 whether, and clearly being a little more cautious
19 about the notion of completely pulling apart the
20 bailing wire and chewing gum which this system has
21 been essentially paying for itself.

22 A variety of I think shared savings
23 programs would be a terrific set of incentives.
24 And that is it kind of goes to I think what the

1 presentation earlier showed with Professor
2 Altman, and that is trying to within the context
3 of the current rate structure start to move
4 quickly towards more market forces and more
5 qualitative outcomes where essentially savings in
6 certain areas are identified at the beginning of
7 the year in a population.

8 And that that allows some liquidity in
9 the potential premium so the providers can use
10 that flexibly to do some of the work on the
11 infrastructure side to create a care package, and
12 then savings would be shared. Perhaps the ways
13 in which those savings would be shared might be
14 different, the providers it serves, the
15 population it serves and the quality outcomes
16 achieved with that population.

17 It's real money. It's putting money on
18 the table. It's saying, look, this is the amount
19 you got to pay last year. If you have a ten
20 percent savings from last year, we'll share it in
21 this way. You'll bear some risk

22 MODERATOR WEIL: Who would have
23 structured the population for which you are
24 looking?

1 SPEAKER GOTTLIEB: I think purchasers
2 like Dolores who are in special positions to look
3 at populations who truly understand what the
4 highest risk is and where hopefully the payers can
5 also describe with their data who those people are
6 with highest risk of utilization would be where
7 the most money is for that because that's where
8 the most savings is likely to be.

9 I think you can step that down even to
10 the broader commercial population. I think this
11 requires a partnership among the payers and
12 providers to be able to look very, very directly
13 where the savings are. That's not something
14 we're able to do before. It does seem the
15 climate is a little more catalytic --

16 MODERATOR WEIL: Let me try to take that
17 and generalize the comment. If there's a vision
18 down the road of accountable care organizations
19 and bundled payments, from a dollar perspective,
20 the yield is highest on the cusp populations.

21 If we could in the shorter run segment
22 out a subset of this massive 6 million or however
23 many people we're talking about to those that are
24 driving the largest set of costs and develop some

1 market-oriented incentives for savings and out
2 population, that could potentially move dollars
3 much more quickly than reorganizing an entire
4 delivery system oriented toward the population as
5 a whole.

6 SPEAKER GOTTLIEB: First, it's the
7 easiest population to get waivers for for some of
8 the barriers would be mitigated because of the
9 earning waivers that exist. Medicaid has much
10 more flexibility in experimentation.

11 In the state, there are some wonderful
12 Medicaid payers like the one to my right who have
13 the ability to participate in those kinds of
14 partnerships. And frankly, you know, if our
15 overall mission is to take care of the sickest
16 and neediest populations and in this state where
17 we have been gifted in having extraordinary young
18 people come here who are focused on those
19 mission-related issues, we'll have solutions that
20 effect this kind of care relatively rapidly.

21 MODERATOR WEIL: I want to shift to the
22 next topic. I know the reports put a laser focus
23 on price. I think in research with other payers
24 and from experience with price regulation, we know

1 that volume can very quickly dominate whatever
2 efforts you make with respect to price. And so
3 even as we focus on price, let's talk about the
4 volume side of this.

5 And again, we're looking now for sort of
6 the quick wins because there's this hope and
7 optimism that longer term system reorientation
8 can bring together price and volume in a way that
9 yields positive results. So my question would
10 be, Are there changes in benefit design that can
11 relatively quickly address some of the volume
12 driven increases in overall costs?

13 I share Dolores Mitchell's version to
14 the term skin in the game. I always like it when
15 someone calls that rather obnoxious phrase out.
16 So I will endorse it. Other than simply shifting
17 costs in a way that we think will drive down
18 utilization irrespective of its value, what can
19 we do in a benefit, in the area of benefit design
20 or other steps that would address some of this
21 volume driven price increase or volume driven
22 cost increase?

23 SPEAKER ENOS: Well, I'm not going to
24 comment on the benefit design. In terms of

1 another area, and to pick up on something that
2 Gary was talking about, he used the term
3 partnership a couple of times. And these hearings
4 are rightfully focused on cost.

5 But I think it's important to recognize,
6 and I feel personally that the real sort of
7 opportunity here is in this partnership. Cost is
8 clearly an issue that we need to tackle. But in
9 collaborations we have, and we have them with
10 many people at this table, the cost is not the
11 only thing that we're collaborating on.

12 So it's a more of a comprehensive
13 approach of looking at the cost of services to
14 our members, but also collaborating on clinical
15 programs, patient outreach, et cetera. So I
16 think that's an important sort of comment.

17 With respect to sort of utilization in
18 that concept of partnership, I think one of the
19 critical things, and health plans do this now,
20 but I think we can do more of it and do it in a
21 way that is more readily available for providers
22 is the shared power of information.

23 Often times we find that providers may
24 just not know what services their sort of

1 patients are getting. They know what they are
2 providing themselves. Depending on the system
3 and the sort of whether or not there's electronic
4 records, et cetera, they may have that
5 information.

6 But often, they really don't know what's
7 happening outside of their walls. So one of the
8 most critical things is, and health plans can do
9 this, is to derive that information as quickly as
10 possible back to the providers. And often
11 enough, it's a matter of just realizing what is
12 happening with respect to their members, if
13 they're accessing specialists that the provider,
14 primary care doctor may not have known about,
15 what what's happening with their prescriptions,
16 et cetera.

17 That one thing of bringing that
18 information back in a very quick way to the
19 providers and in a setting that that can be
20 shared, you know, I have seen that in and of
21 itself has made a difference.

22 MODERATOR WEIL: What does it take to
23 make more of that happen?

24 SPEAKER ENOS: Well, I think there is, as

1 had been said before, in some cases there are
2 investments in terms of the technology to be able
3 to share that information. Actually, there is a
4 fair amount of that now. I think it's more not
5 even the technology as much as it is, What do you
6 do with the data?

7 It's one of the things we've learned
8 just shooting data out to providers is not
9 necessarily the answer. It's a matter of having
10 the data, having it readily available, but then
11 also having a forum to sit down and discuss it,
12 to show them benchmarks with respect to their
13 peers.

14 It's really what is the construct in
15 which the data is reviewed. I think you can set
16 up mutual goals that work both for the members,
17 for the providers, for the health plan in those
18 settings. But you need a contract. We have a
19 lot of data all over the place. It's how you
20 bring it together and use it in a collaborative
21 way. It does include an investment of time.
22 It's really resources, professional resources on
23 both sides that invest the time to do that
24 together

1 MODERATOR WEIL: If I were to expand my
2 question about volume to also include provider mix
3 as another source of cost pressure, I'm going to
4 ask Dr. Lopez, you have this large multispecialty
5 system. How in that system do you try to keep an
6 eye on and what again policies can support your
7 assurance that when or making pressure on price it
8 just doesn't just come out on the volume side?

9 SPEAKER LOPEZ: Well, you know, I think
10 we have a large network of primary care and
11 specialty providers. And so that, all of whom are
12 sort of oriented towards the same goal in terms of
13 our organization and are tied together with the
14 common electronic medical record.

15 I think that is, and it still gets back
16 to the IT thing that is really critical. Because
17 we all can see what we each are doing, and it
18 allows coordination of care in a way that when I
19 have patients whom I'm only seeing as a primary
20 provider and they're getting their specialty care
21 elsewhere, it's just not possible.

22 So you know, certainly organized around
23 a common electronic medical record allows for
24 that kind of coordination. Another point here is

1 that coordination is only possible around the
2 selection of a PCP. And that's, so it gets back
3 to the choice issue. But it's a reality. And a
4 patient who has selected a PCP, that PCP is, has
5 more access to information than in an otherwise
6 sort of unimagined product.

7 A typical example, my patient gets
8 admitted to the hospital. The hospitals knows
9 who the PCP is. So they send me information. A
10 PPO patient or Medicare patient, straight
11 Medicare, I get no information because there's no
12 particular reason. The hospital isn't mandated.
13 They don't necessarily know. So selecting a PCP
14 is also critical.

15 MODERATOR WEIL: So I feel like these are
16 tools, but not necessarily the push. And maybe we
17 don't need a push. But I'm interested in some of
18 the push side as well.

19 SPEAKER DE LA TORRE: I just want to
20 caution, and everyone sees where I stand
21 especially on increase in health care costs. But
22 we always have to be careful of the law of
23 unintended consequences.

24 One of the realities in a

1 fee-for-service environment, hospitals,
2 especially community hospitals are priced on the
3 margin. What do I mean by that? It's that last
4 X amount of delivery is the entire margin, the
5 entire profit lien of a small community hospital
6 and are already down around 1 percent.

7 So if you set up a strict, a structure
8 where, remember, we have competing interests in
9 communities. We have physician groups that own a
10 lot of imaging, that do a lot of outpatient
11 surgery. We have other centers that do their own
12 imaging that compete with the hospital.

13 What happens is if you drive
14 utilization, you're going to bankrupt community
15 hospitals because, you know, you're literally
16 stripping their margin because the inpatient care
17 doesn't really make a heck of a lot of money.
18 And the outpatient setting has already been
19 stripped by a lot of these other providers.

20 So we have to be careful that in a
21 fee-for-service, in a pure fee-for-service
22 environment, without a payment reform, if you do
23 something like that and really drive down
24 utilization, be prepared for a bigger commission

1 desk type of consolidation. That is a different
2 issue for a different day; but we just, you make
3 sure we understand that.

4 SPEAKER GOTTLIEB: The payment incentives
5 are critical in order to be able to ease the over
6 utilization which particularly the report showed
7 us so eloquently were focused on very large
8 increments on the ambulatory side.

9 Not only were we encouraged for years,
10 but the incentives have driven the use of mostly
11 technology on the ambulatory side. The rapid
12 dissemination of that technology and without
13 moving pretty quickly to some subset of bundled
14 payments that look specifically at disorders,
15 we'll have people who are driven by pretty low
16 specificity tests that are very low sensitivity
17 associated with them in order to respond and are
18 also responding to a set of incentives.

19 The other element, and I don't know what
20 its overall value is, but those who are fearful
21 of some kind of litigation seem to use those
22 resources extensive. And I would say that you
23 know that's probably an overvalued component.

24 However, there is something that I think

1 the Division of Insurance could do that could be
2 helpful to us in that regard. The more that data
3 can be shared as to how one reduces overall
4 liability, the more that that can be used as
5 learning and teaching to improve behavior and
6 quality I think would be remarkable.

7 We have the great fortune of being part
8 of a captive that relates to the Harvard teaching
9 hospitals and has basically very, very
10 transparent data and has created with it a set
11 curriculum that focuses on specific high risk for
12 physicians and also looked at a variety of other
13 components.

14 If we believe that ordering behavior in
15 terms of over utilization of high cost imaging is
16 driven by fear of litigation, all we would need
17 to do is truly inform ourselves based upon the
18 data, try to look at operational components from
19 which we work together and sharing those data
20 across the system.

21 Most of the commercial carriers I know
22 are pretty opaque in terms of sharing those data
23 with the groups. So it could be an opportunity
24 to just throw that tort issue aside and allow us

1 to really work again with information sharing.

2 MODERATOR WEIL: I'm struck by a chicken
3 and egg problem that maybe was obvious to everyone
4 else, and just I'm slow to come to it. On the
5 utilization side with the margins that Dr. de la
6 Torre you mentioned, without payment reform,
7 efforts to drive down utilization are going to
8 drive institutions out of business. And they will
9 complain before they let that happen.

10 But in order to do payment reform, you
11 need a different delivery system to receive those
12 payments to do the right thing with it, and the
13 capacity of the system to do the right thing with
14 those payments is limited. And it seems to be
15 particularly limited to those places that are
16 most fragile with respect to utilization.

17 So where do we start in trying to
18 address the utilization component of this
19 simultaneously with payment reform without just
20 making the system collapse?

21 SPEAKER DE LE TORRE: Non-hospital-based
22 utilization.

23 MODERATOR WEIL: Say more.

24 SPEAKER DE LA TORRE: You know, we were

1 just talking about on the margin of hospitals that
2 if you strip them of a lot of their outpatient
3 procedures like imaging and surgery that you're
4 going to drive them into bankruptcy, there's no
5 doubt, without late payment reform already in
6 place.

7 Yet, there are a lot of providers that
8 are not hospitals that are either large groups or
9 imaging groups or surgicenters, et cetera that
10 take out the high profitability procedures,
11 testing, et cetera from the hospitals.

12 And I think there is a realm of
13 utilization that does not necessarily contribute
14 to the overall margin of healthiness of hospitals
15 or ACO's per se that we need to identify and deal
16 with.

17 MODERATOR WEIL: So obviously, they're
18 not going to be any happier taking it out than
19 anything else, so the risks to the citizens of
20 that lost revenue are smaller?

21 SPEAKER DE LA TORRE: Well, if you go
22 with the fundamental assumption that we need to
23 decrease utilization, let's start with everybody
24 agrees with that, then what follows if you look at

1 the margins that community hospitals generate and
2 you ask any community hospital CEO or CFO, if you
3 take 5 percent of your imaging or 10 percent of
4 our outpatient procedures, what's going to happen
5 to your bottom line?

6 They're all going to answer the same
7 way. We're going to cease to exist. We're going
8 to have to accept a certain amount of hospital
9 closures with redistribution of volume, or we
10 have to prevent the decrease of those volumes
11 while decreasing out utilization in these
12 community hospitals.

13 Again, that's a much bigger decision.
14 That's really what it comes down to.

15 SPEAKER ZANE: I really believe that all
16 roads lead back to fixing the basic inequities in
17 the market. Yesterday, I believe Dianne Anderson
18 at Lawrence General Hospital spoke about how it's
19 impossible to sustain a community hospital when
20 they're being starved.

21 When you think about how we're going to
22 preserve the high quality, low cost community
23 hospitals, all roads lead back to the same issue.
24 We can't dance around that. We have to fix it.

1 COMMISSIONER MORALES: So Ellen, how --
2 can you share some ideas as to how you would
3 effected by that.

4 SPEAKER ZANE: When I go back to the
5 concept of a fix, I think where state government
6 can have a role, and I'm not going to assume what
7 exactly that role is, David, we have to be able to
8 somehow say that the gap that currently exists
9 between the higher reimbursed and the lower
10 reimbursed has to not exceed X, whatever that is,
11 so that the Lawrence General Hospitals of the
12 world can reinvest in themselves so that the
13 problems that Ralph articulates don't keep them so
14 marginalized.

15 SPEAKER GOTTLIEB: The one problem only
16 in that area is that those hospitals find
17 themselves in communities that were different than
18 when they structured themselves. If in fact those
19 inequities are fixed, they may find themselves
20 with different payer mixes. It becomes a
21 challenge.

22 SPEAKER ZANE: As I said earlier, all
23 payers have to participate. So this clearly,
24 we're cost shifting. Some of us we're able to

1 cost shift to the commercials better than others.
2 But my comment in my testimony about government
3 stands.

4 MODERATOR WEIL: So I want to try to pull
5 this in to the next level which is we had a
6 discussion about the price and volume market
7 approaches, limited ideas, but very good ones.
8 Then there's tendency to ask sort of what the
9 regulation can do.

10 I am confident in the time remaining we
11 could not work out the details of a regulatory
12 structure. So we're not going to try that. But
13 maybe we can talk about a kind of infrastructure
14 issue, the state-based necessary to create the
15 kind of policies that you all have discussed as
16 the types of regulation that might be necessary
17 to ask the question is it possible to think of
18 regulation as a short-term solution?

19 After all, if everything you're going to
20 regulate you're going to spend five years
21 figuring out what the right number is, then it's
22 not a short-term solution. So the question is,
23 Do you have an infrastructure, and can you
24 quickly create an infrastructure that is going to

1 be credible and that you all are willing to rely
2 upon to make these important decisions about
3 allocations of when we think about when we went
4 through a planning, when the nation relied on
5 health planning, we had the federal government
6 supporting a major infrastructure. You all used
7 to have that infrastructure. It's largely been
8 dismantled.

9 So is there, is there enough of a
10 starting point, a sense of confidence in the
11 capabilities and the capacity of the government
12 to take you down this road of trying to
13 rationalize and use a regulatory structure to
14 overcome some of the disparities that have been
15 demonstrated in the data reported over the last
16 few days?

17 SPEAKER MITCHELL: The answer is out
18 there, not up here.

19 MODERATOR WEIL: What do you mean by
20 that?

21 SPEAKER MITCHELL: Well, I mean, you've
22 got legislative action that has to take place.
23 You have the leadership of the Governor that has
24 to take place. You have the agency heads that

1 have to work with the Governor's office.

2 You have the Attorney General's Office
3 that has power to do certain things. And we do
4 have the insurance commissioner sitting up here.
5 There are some things he could do, I suppose.
6 But by and large, there are more of the
7 decision-makers out there than are on this side.

8 MODERATOR WEIL: So then let me follow it
9 up in a slightly different way which is that
10 without the confidence of those of you up here in
11 the ability of those out there to adopt a process
12 that will be credible, the likely result of
13 regulation is nothing in the way of improvement.

14 We know that regulation in and of itself
15 does not yield lower costs. It's only regulation
16 in the context of willingness to use that as a
17 force for change.

18 So I understand that you aren't the
19 decision-makers, necessarily, on the panel. But
20 your willingness to sit here or stand and say
21 that given the limitations of the other
22 approaches we will endorse a process like that,
23 that's a strong statement. And I want to know if
24 any of you are willing to make it?

1 SPEAKER MITCHELL: But I don't agree with
2 your assumption that regulation doesn't work.

3 MODERATOR WEIL: I don't think I said
4 that. I said that regulation if it's not, if it
5 doesn't have any political force behind it --

6 SPEAKER MITCHELL: Oh, okay.

7 MODERATOR WEIL: -- then it has no
8 effect.

9 SPEAKER MITCHELL: Sorry.

10 SPEAKER ZANE: So what's giving me pause
11 is that I reflect -- I'm old enough to remember
12 when there really was a pretty strong DON process
13 in Massachusetts. And I reflect on how it was
14 politicized and how providers that didn't like the
15 DON process would submit legislation to get around
16 it.

17 So I think the credibility of such an
18 enterprise that government might help promulgate
19 has to be associated with credible individuals
20 who are knowledgeable individuals, maybe not from
21 Massachusetts perhaps, in order to sit over this
22 and give thoughtful, rational, reasonable
23 expertise and not have a seat on such a panel
24 because it's politically correct.

1 That's when it loses its credibility,
2 when the folks that occupy the seats are not
3 really knowledgeable, when they have no on the
4 ground, in the trenches experience of managing
5 anything and when it's politicized.

6 MODERATOR WEIL: So that's a helpful
7 start to a conversation. And I want to ask for
8 more along these lines of what it's going to take
9 to accept the outcome of a process like this.

10 SPEAKER DE LA TORRE: I think that,
11 talking about the politics of it, Ellen, a
12 fundamental problem that every solution that makes
13 sense that we've all talked about, whether there's
14 limited network, payment reform that limits
15 utilization, all those things, the populace
16 doesn't like it.

17 Right now the people that live in
18 Massachusetts don't fundamentally like that.
19 They don't like it, most of us will argue,
20 because they don't understand exactly what that
21 means. But when you put the politicians in
22 charge, and I'm not speaking bad about
23 politicians. I actually have some as friends.
24 You know, they have to get reelected.

1 And it's very tough to sit there and
2 say, you know, I'm sorry. There is no solution
3 that gives everybody in Massachusetts a no copay,
4 no deductible system with infinite flexibility
5 and everything you ever wanted. You can't have
6 it.

7 I think that's what would be my line of
8 stance. If we get a group of politicians that
9 say, you know what, we're going to do this no
10 matter what it takes. If we never get reelected,
11 so be it. We're going to do that. We're going
12 to make it our mission. Then you would see a lot
13 of us jumping on the bandwagon to support them,
14 to do whatever we could to do that.

15 If it's going to be before the easy fix
16 and making the headlines and sound bytes, then
17 we're not going to get out in front of them.

18 COMMISSIONER MORALES: So let me just
19 jump off that point. So we set the table for a
20 conversation. They're in the audience. I guess
21 the onus is on you to say here are the short-term
22 solutions or ideas for you to take up or for us to
23 put in our final report. So if this isn't the
24 space, then what is the space? If this is the

1 space, then we'd love to hear it.

2 MODERATOR WEIL: Wait. The recorder will
3 object. Please.

4 SPEAKER GOTTLIEB: It's different than
5 the question that you asked. And the question is,
6 How do you create a trusting process where some
7 don't get vilified or isolated, where the process
8 is not about threat but an understanding that
9 there's going to be sacrifice all over the system
10 in one way or the other because it's going to have
11 to be re-molded in a certain direction and creates
12 some set of transactional trust to be able to get
13 to that point. That's a hard thing to do.

14 It's a hard thing to do in an
15 environment where you have those kind of charts
16 and where there are ups and downs in the system
17 and where care is sporadic and where essentially
18 you have a market that's evolved over a period of
19 time for a variety of different reasons without
20 thoughtful policy.

21 The state took a step to put forward
22 policy around the social elements of justice. I
23 think the world should applaud that as the
24 President of the United States is trying to do.

1 That is without saying. Now the question is
2 collectively, how do we hold on to the
3 preciousness of that, protect it in a way that's
4 consistent with the extraordinary value that
5 exists here.

6 Don't throw the baby out with the bath
7 water and still be a leader in technology and
8 academics and other components while not
9 essentially bankrupting extraordinary small
10 institutions who would be frail in that regard.
11 That's a real lot of compromise. And there's
12 going to be a trade-off in that regard.

13 I know each of us has simple solutions
14 around that. In order to entrust a source to be
15 the authority, to be the truth which is what the
16 government ends up being in this circumstance, we
17 have to figure out what the parameters are of a
18 real workable partnership and to some extent
19 understand that the expedience of a solution that
20 comes before election day or a certain time is
21 much harder to get. It's really harder to get.

22 There's so much good, which I think
23 Dr. Altman was saying to us, and there's so much
24 problem which is what Dolores has described to us

1 and what the marketplace tells us that to think
2 about a thoughtful kind of outcome is really
3 going to take a lot of work and a substantial
4 amount of trust.

5 So to just say we're going to empanel
6 this group or to say we're going to use the
7 authorities invested in me by law to come up with
8 an outcome is not going to have that form of
9 partnership. I apologize for not knowing the
10 size or the shape of the panel. Even Stuart
11 Altman couldn't come up with one that exactly
12 works.

13 Certainly, the I-cap that's in the
14 current bill that the federal government has
15 isn't one that all of us thought about anyway. I
16 think in sympathy to Ellen, I think what the
17 President tried to do is consider having the
18 general accounting office be the appointer. So I
19 think you have to be very, very careful. But I
20 think it's critical to do it, to try to put on
21 the table now how we're going to create this
22 trust.

23 MODERATOR WEIL: I want to follow on
24 that. I really appreciate the way you put that.

1 Part of why I raise this question is if there's a
2 sense that we're in crisis and we need to move
3 fast and regulation is viewed by many as a blunt
4 but maybe necessary instrument, I want to pose the
5 question of whether we can move quickly with
6 regulation or whether all of these trust issues
7 that you described needing to work out are going
8 to take too long for us to yield results.

9 But I also do want to hear concretely,
10 not just sort of we will embrace regulation if we
11 like the process, but what that needs to look
12 like so that the process if that's the path that
13 the Commonwealth is going to take will begin.

14 SPEAKER MITCHELL: I don't know.
15 Machiavelli said, what, 600 years ago or so that
16 when you have a system which by and large works
17 for most people, they will fight to the death to
18 keep it from being changed. Whereas those who
19 might benefit from a change are not organized
20 enough to demand that change and fight with
21 significantly less passion because I don't know
22 that they would get a better deal if they accepted
23 change.

24 We're certainly seeing that in

1 Washington. I mean, that's exactly what's
2 happened over the past six months. We're going
3 to get something on Sunday I understand from this
4 morning's paper. Not what some of us wanted.
5 But you know, you look at the history of social
6 change in this country, you see that it has only
7 come when the middle class, itself, gets
8 effected.

9 And we thought we had that in the
10 current situation. And yet, it still didn't
11 work. I think partly because of the animosity
12 and anger that's out there and the fact that when
13 you're talking about health care, you know, that
14 hits at home much more emotional than almost any
15 other social program can be.

16 So I think it's a very large hurdle to
17 meet, but I would hope that the political
18 leadership -- and unfortunately, we're also in an
19 election year. Let's face it. That makes life
20 much more complicated. So I cannot see after the
21 election in the fall, however it turns out, that
22 we can get the senior leadership of the
23 Governor's office, the Attorney General's Office,
24 the regulatory folks who are sitting over there

1 and out there together to push together for it;
2 but otherwise, I think it's going to be very
3 hard.

4 I don't think just bringing in something
5 like a base closing commission is going to do the
6 trick. You know, and data won't do the trick
7 either. You can show that some of the hospitals
8 whose potential closing is most passionately
9 opposed by the neighbors, and then you look at
10 where the neighbors actually went to get their
11 care. And none of them use those facilities. So
12 closing a neighborhood school, it may be a lousy
13 school, but it's our school.

14 MODERATOR WEIL: I think we're moving a
15 little bit too much into distraction. So I want
16 to ask a final, I want to ask a final question
17 which is regardless of the exact techniques, I'd
18 like you to offer some guidance to leadership in
19 this room.

20 We again are here and motivated by the
21 sense with lots of data supported among the
22 citizens of the Commonwealth that cost is a
23 problem. And there's been terrific analysis to
24 show what's driving it. Where in that big puzzle

1 is it?

2 Is it at the hospital level? Is it at
3 the system level? Is it at the insurer level?
4 Where do you suggest, regardless of the technique
5 that the focus be placed on, within the system to
6 yield quick and not harmful to the public changes
7 that will help address this cost problem?

8 Where do you think the focus ought to go
9 first if we're trying to do something to address
10 what the, what the public views as a crisis?
11 I'll let you start.

12 SPEAKER ZANE: In fairness, I think we've
13 answered that question.

14 MODERATOR WEIL: I know you have. But
15 I'm not sure everyone --

16 SPEAKER ZANE: All of us have talked
17 about our ideas, whether it's limited networks or
18 chronic disease management or whatever. I think
19 we've said where we would begin to go down that
20 path. Where I'm bringing is the constant drum
21 beat of where are we going to get a quick fix
22 because I believe that's naive.

23 There are so many moving parts to all of
24 this. And to say we can chop something and not

1 have a downstream effect I think is dangerous.
2 We need to be careful irrespective of which
3 part --

4 SPEAKER DE LA TORRE: In order to do what
5 we're going to do tomorrow, where we're going to
6 head home, we need an understanding of where we're
7 going to be in three years or five years. Then we
8 can embark on the dream. Then we can ask the
9 question, What can we do immediately that doesn't
10 hurt our plan for three to five years?

11 MODERATOR WEIL: I think that's certainly
12 appropriate. And as I think about the principles
13 for effective short-term change, clearly one of
14 them is to be consistent with your long-term
15 vision. But I worry that as I believe, as Deb
16 Enos said at the outset, you're eight months into
17 your five years, and you're not there yet.

18 And it's going to take awhile to agree
19 on this vision with that level of specificity.
20 If the notion is we can only do short-term after
21 we've defined long-term, then short-term is
22 already gone.

23 So with total respect to the maybe
24 naiveté and maybe unrealistic notion that you can

1 move this system in ways that aren't harmful,
2 that's what people are asking that we try to do.
3 So I think it's unrealistic to just say the
4 answer is that there's nothing that can be done
5 in the short-term until --

6 SPEAKER ZANE: I think it's really unfair
7 to say that we said there's nothing. We have not
8 said there's nothing.

9 SPEAKER DE LA TORRE: Yes.

10 SPEAKER ENOS: To echo something I said
11 and I think to echo what Ralph said, we have to
12 start the plan. We're eight months in. We'll
13 never get there if we don't start. That's a real
14 thing. Whoever is supposed to own that needs to
15 start that process and get a plan.

16 No. 2, we've mentioned limited network
17 several times. I look over at Commissioner
18 Murphy, change I would recommend, at least look
19 and consider changing your policies concerning
20 how to designate a service area. The
21 requirements of which providers need to be in
22 right now, they're restrictive. They do not
23 facilitate limited networks.

24 You require that too many providers need

1 to be in and relax the ability of plans to
2 differentiate through copayment so there's an
3 incentive for consumers to opt into the more
4 select network.

5 Third, with respect to more
6 publicly-funded programs, we need a strategy of
7 how to work within extremely limited resources to
8 maximize efficient uses of delivery systems and
9 providers. And that is under their control.

10 We don't need additional regulation. 85
11 percent of my business is under that control, and
12 every single day I beg for that. Hopefully
13 that's specific.

14 SPEAKER MITCHELL: And we have a
15 five-year recommendation. It's called a payment
16 reform commission recommendations, and it was a
17 unanimous vote I might add. And that's sort of
18 what I meant when I said the answer is largely out
19 there.

20 I represent Ms. Stanley who's smiling
21 because she knows I'm about to throw a hot potato
22 in her lap, that they need to get started on it.
23 Deb is absolutely right, and she was right when
24 she started an hour ago.

1 SPEAKER GOTTLIEB: Well, the biggest
2 piece of crisis is the burden on government
3 because the government is the most painful, is a
4 part of the system that is in the most pain at the
5 moment and where our leaders are going to have the
6 most difficult choices among things that are all
7 precious to us.

8 I think the latter component of what you
9 described, Deb, that is focused specifically on
10 very, very high users and that sub-population
11 where you can scale up existing programs rapidly,
12 hold us accountable to scale them up, that's
13 going to change things. It's going to cost us
14 because we're going to end up with over utilized
15 capital.

16 SPEAKER DE LA TORRE: I want to disagree.
17 I think the biggest problem we're facing is not
18 the impact on government. Government has never
19 pulled this country out of deep recession. Small
20 business have pulled the country out of deep
21 recession. So we need to figure a way to help the
22 small businesses in our community right now.

23 SPEAKER GOTTLIEB: But they're
24 subsidizing what government can't pay anymore.

1 SPEAKER DE LA TORRE: In that case, we're
2 all intertwined. But it's really, the impact on
3 small businesses are getting crushed. And that's
4 what some of the limited networks potentially, we
5 talked about -- if you go through the transcript,
6 there were a series of ideas that you can do
7 immediately.

8 What I'm saying and what Helen has said
9 and what others have said, as you do these, you
10 have to keep in mind the results of the payment
11 reform commission and where we're headed and ask
12 yourselves, as I put this policy in place, does
13 it give me a quick fix but move me away from that
14 goal, or does it move me towards that goal?

15 MR. O'BRIEN: First, I want to thank the
16 panel and the moderator for the lively discussion.
17 I know we're finishing up soon. I know there are
18 been some good ideas and have been indicated well.

19 I want to get to the idea that Dr. de la
20 Torre has. There needs to be a cultural shift
21 with consumers and how they interact with health
22 care. I think this shows in Dr. de la Torre's
23 comment whether there also needs to be a cultural
24 shift in the providers' side.

1 To the extent that outside, there's a
2 lot of topics. There's a lot of arms race going
3 on. There's a lot of advertising. There's a lot
4 of business. I understand that, you know, we
5 recognize that it is a business. It's big
6 business.

7 But whether it's a chewing gum kind of
8 luxury tax that you mentioned, are there some
9 things that are existing with payment reform over
10 time that the provider community can take on to
11 kind of change some of the culture of competition
12 that makes it positive rather than what someone
13 might perceive as driving just larger footprints
14 to certain entities?

15 SPEAKER DE LA TORRE: It does potentially
16 cap on the top end profitability and takes some of
17 those and drives it into fund government programs
18 to help with other things. And yet, what it does
19 is it's going to incentivize people. We're all
20 businesses. We're going to find ways to make
21 profit.

22 So if you create the avenue to profit as
23 an incentive to creating, to accept payment
24 reform, then by kind of minimizing the high end

1 impact of fee-for-services, you accomplish two
2 goals. You get a short-term fix while heading in
3 the right direction.

4 SPEAKER GOTTLIEB: Certain payment reform
5 will reduce any arms race. Once you reduce
6 bundled payments or global payments or in some
7 kind of shared savings as described very early,
8 then essentially capitalization has very minimum
9 value unless it substitutes for something that's
10 otherwise more expensive.

11 That's working capital around practice
12 models that may be more efficient or effective or
13 substitution of more expensive stuff. So driving
14 in that direction along the very streams I think
15 we've described here and by the Payment Reform
16 Commission have value in change of what you're
17 describing.

18 Obviously, it will create more anxiety.
19 Anxiety creates more competition. Hopefully the
20 competition will be around being qualitative and
21 showing value per unit of service. And with
22 trying to emerge with measures that can
23 differentiate providers, I think one of the
24 issues, I think you did a great job for trying to

1 use all of the available quality measures. That
2 having been in health quality services for much
3 of my life and policy, we know what information
4 is available to us, and we can't differentiate
5 well in the key areas or key provider.

6 They're going to have to be very disease
7 specific, treatment specific and where the
8 highest costs are so you can measure cost per
9 unit of value in the very high dominated areas.
10 I think we have to move this stream of gradual
11 payment reform in order to make changes.

12 MODERATOR WEIL: So if I may, I was asked
13 to make a few summary comments at the end. I will
14 begin those now. I think it's great that you have
15 someone not from Massachusetts moderating so that
16 as the anger on the panel grew when I get on an
17 airplane, it will all be gone.

18 But a few observations are from my
19 experience both with my years at work with the
20 Commonwealth but also other states, the first is
21 don't undervalue the consistent, the consistent
22 support you have for the long-term vision created
23 by the Payment Reform Commission. That is a
24 tremendous asset. And although clearly there is

1 work to be done to give that vision meaning, it
2 is such a bold statement heard around the
3 country. And it is a platform from which you can
4 work.

5 Second, if you're thinking about the
6 importance, and I'm sorry, I did focus so much on
7 short-term cost control because of the sense of
8 crisis, it does seem that there are a few
9 principles to guide whatever you do in the short
10 run. The first is that it needs to be
11 incremental. You can't -- you're going to have
12 too much opposition if you change anything too
13 much too fast. Then it just won't happen.

14 Second, it needs to be reasonably simple
15 because you can't do complex things too fast.
16 And third, it needs to be consistent with your
17 long-term vision. If you do things in the short
18 run that make it harder for where you want to go,
19 that makes it bad for a lot of different reasons;
20 and it also won't work.

21 The third observation I will make, I
22 think there's a very compelling case to be made
23 that the investment in transforming your delivery
24 system into one that can operate in a capitated

1 bundled payment model, it's a social good. And
2 we have models available to us to think about how
3 to fund social goods.

4 You could, for example, have a fund, a
5 state-administered fund with competitive grants
6 to organizations that made the case that they
7 need the resources to do this. Part of the way
8 they make the case that they need the resources
9 is by pointing to this chart and saying those
10 resources haven't been built into our rates.

11 If you think about the movement around
12 the country towards building patient center
13 medical homes, there are state-based
14 infrastructures being developed around the
15 country to support individual practice change.
16 I'm not trying to suggest these two are the only
17 models.

18 But once you realize that that
19 investment is necessary to achieve your long-term
20 vision, you can treat it as a good that should be
21 funded and supported and designed through a
22 separate stream and not just built into your
23 pricing which is still, despite all of this
24 information, rather opaque. And that gives the

1 opportunities to do things you wouldn't have
2 otherwise been able to do.

3 Fourth, I think it is important as you
4 think about the challenges you have in shifting
5 your delivery system that you do keep an eye on
6 the actuarial yield of the relatively small
7 portion of the population that drives the largest
8 share of the costs and who, frankly, in many
9 respects gets some of the worst and uncoordinated
10 care.

11 It is good for people and good for costs
12 and frankly less descriptive to the whole
13 delivery system to focus on a subset. If you're
14 going to focus on a subset, don't focus on the
15 cheap commercially insured folks whose services
16 are provided throughout the health care system.

17 But focus on a higher cost population
18 where, again, we know the need for improvement.
19 And frankly, your leverage for change are more
20 internal because it's more Medicaid than ERISA or
21 Medicare or other sources that might be
22 challenging.

23 I've lost count, so I think I'm at five,
24 which is I was struck by and intrigued by the

1 great interest in tiering and limited networks.
2 I think that's a ball to run with. And again, I
3 don't know that I got quite the answer I would
4 want for whether this is about pedagogy, just
5 showing people what they're paying for; or if you
6 can really tier on quality; or if it's just about
7 price. But it almost doesn't matter.

8 This is a direction that there's enough
9 interest in and there's some identified barriers
10 that it's worth trying to figure out how to get
11 over those barriers.

12 Next is I do have to say that some
13 serious effort is going to have to go into the
14 next layer of analysis which is disentangling the
15 cross-subsidies. Everyone can make a case for
16 why their costs are higher than average.
17 Everyone has a story for what they do that other
18 people don't do.

19 When we worked on the blueprint for
20 coverage trying to figure out where those DSH
21 dollars were coming from and where they were
22 going was not an easy thing. This an order of
23 magnitude more complex. If you're going to have
24 political support and consumer support and public

1 support for any kind of movement, you're going to
2 have to drill down into those cross-subsidies so
3 that you're not just looking at one payer at a
4 time. You're not just looking at a consistent
5 set of services.

6 You're taking seriously the arguments of
7 why people are making arguments of why their
8 costs are outliers and then creating evidence
9 based on that discussion so everybody isn't, of
10 course, well, I'm different.

11 My next comment harkens back to
12 Professor Altman's comments about his sort of
13 three-tiered approach. If you're serious about
14 cost containment in the short run, it's hard to
15 imagine doing it without some sort of aggregate
16 cap on spending.

17 I think his notion that you need to
18 treat how you apply that cap in different care
19 delivery settings and financing settings is a
20 very good way to start. I'm not saying do it.
21 I'm saying if you want to do it, you need to
22 think of it that way.

23 Even if the rate of growth is the same
24 across settings, how you apply that rate of

1 growth is going to differ. I wasn't here when
2 Steve Schoenbaum spoke yesterday morning, but I'm
3 a member of the Commonwealth Commission on a high
4 performance health system. Part of our work has
5 been building a chart that I think is helpful
6 that notes that different levels of aggregation
7 create different opportunities for global
8 payments and bundling all the way up to full
9 capitation.

10 You have a system of variable structure
11 and variable payments behind that structure. So
12 if you're going to anything that looks like a
13 cap, you do have to apply it differently. And I
14 think that insight in his proposal is critical.

15 And finally, and yes, this is the last
16 one, I do have to say I've been struck over the
17 last couple of days, and I mean to pick no fights
18 in my final comment, by the number of references
19 to the people and they want everything and they
20 don't want to pay for it and this and that.

21 I have to say I find although I know
22 that that's never the whole feeling that's being
23 expressed, I find that very destructive. It's as
24 destructive from my perspective as talking about

1 skin in the game.

2 As a non-clinician who's just
3 periodically a patient, I have to say the
4 overwhelming majority of what I do is because my
5 doctor says I should do it. And I need guidance
6 from -- I know that I need guidance from other
7 people to make good decisions.

8 And so although I think the endpoint of
9 a lot of the discussions about people being
10 disconnected I would agree with, we need to
11 integrate and engage. We need to integrate and
12 engage people with the respect that's due to them
13 about their capability of engaging.

14 Sometimes I fear that the language that
15 we use to say that they don't get it is not a
16 real inviting way to bring people in to
17 participating in their care and to participating
18 in the cost problems that we confront.

19 So I will just say as an outsider, I am
20 impressed by the level of analysis done by you
21 all and your staff and the commitment of the
22 panel, the level of thought in the state that you
23 have demonstrated once again your leadership on
24 these issues.

1 I can only wish you good luck in taking
2 the next steps; but please those of you in the
3 audience, join me in thanking the panel for their
4 contribution.

5 COMMISSIONER MORALES: Thank you so much,
6 also to Alan for his work as moderator. Round of
7 applause. Thanks again to this panel for its
8 open, pointed and robust discussion. I appreciate
9 it.

10 A couple of more things. Before we
11 break, I want to thank again the panel for an
12 open, pointed and robust discussion. It was
13 very, very helpful. Second thing before we
14 break, also I want to acknowledge some folks I
15 didn't get to acknowledge here earlier who are
16 here now, Commissioner Joe Murphy, Secretary
17 Barbara Anthony, thank you for being here, as
18 well as Representative Mary Grant who is here
19 also.

20 When we come back at one o'clock sharp,
21 we will hear from some public testimony. Lastly,
22 we will also hear from Assistant Attorney General
23 Tom O'Brien who will examine a couple of
24 individuals from Tufts Medical Center and Paul

1 Everett from Beth Israel, I believe, as provided
2 by Chapter 305 of the Acts of 2008. Thank you.
3 See you all at one.

4 (Whereupon, the proceedings suspended at
5 12:30 p.m.)

C E R T I F I C A T E

COMMONWEALTH OF MASSACHUSETTS
ESSEX, SS.

I, Christine L. Warwick, a Notary Public and
Certified Shorthand Reporter duly commissioned and
qualified in and for the Commonwealth of
Massachusetts, do hereby certify that the
preceding transcript is a true and accurate
transcription of my stenographic notes taken in
the foregoing matter taken to the best of my skill
and ability.

IN WITNESS WHEREOF, I have hereunto set my
hand and Notarial Seal this ninth day of April,
2010.

CHRISTINE L. WARWICK
Notary Public
Certified Shorthand Reporter

My Commission Expires:
May 14, 2010

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Massachusetts Health Care Cost Trends Final Report

Appendix C.5f

Health Care Cost Trends Public Hearings

Transcript for Afternoon Session Friday, March 19, 2010

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COMMONWEALTH OF MASSACHUSETTS
DIVISION OF HEALTH CARE FINANCE AND POLICY

ANNUAL PUBLIC HEARING UNDER
M.G.L. CHAPTER 118G, Section 6.5
HEALTH CARE PROVIDER AND PAYER
COSTS AND COST TRENDS

PANEL:

David Morales, Commissioner, Department of
Health Care Finance and Policy
Louis Johnson, Office of the Attorney General

HELD AT:

University Club, 11th Floor
Joseph P. Healey Library
University of Massachusetts, Boston
100 Morrissey Boulevard
Boston, Massachusetts 02125
On Friday, March 19, 2010

Afternoon Session Commencing at 1:00 p.m.

COPLEY COURT REPORTING
The Mercantile Building
78 Commercial Street, Suite 700
Boston, Massachusetts 02109
(617) 423-5841

1 P R O C E E D I N G S

2

3 MR. MORALES: I do acknowledge and invite
4 to the podium, Inspector General Greg
5 Sullivan.

6 MR. SULLIVAN: Thank you very much,
7 Commissioner Morales.

8 For the record, I am Greg Sullivan,
9 State Inspector General, and I thank you
10 very much for the opportunity to present
11 some testimony here today. This great
12 initiative that you've undertaken. I'd
13 like too make a recommendation, which I
14 want to present you today and I think
15 that it's indirectly, but also in many
16 ways highly related to what you're doing.

17 First, though, let me acknowledge the
18 work that you're doing with respect to
19 commercial payers and the affordability
20 of insurance in the private marketplace
21 for individuals, families and groups and
22 business people in Massachusetts. Since
23 the health reform act passed, premiums
24 have gone up between 40 and 50 percent.

1 I saw in the comments yesterday of
2 Congressman Steve Lynch, in his objection
3 to the healthcare plan in congress, that
4 he felt that the plan does not have
5 adequate control on costs, not enough
6 pressure on costs. That is a theme that
7 the Inspector General's office has been
8 trying to tout around Massachusetts about
9 our plan.

10 This process that you've undertaken
11 as a result of the legislative reforms
12 and Senate President Murray and all the
13 other others who initiated this process,
14 you're looking to find a way to put that
15 pressure on, and that is very commendable
16 to be able to do that.

17 My brother is a small businessman.
18 He's a one-person businessman and his
19 family plan for health insurance is
20 \$21,000. And as he pointed out to me,
21 that represents \$10 an hour that he pays
22 based on a 40-hour workweek for health
23 insurance after tax, and that's a lot of
24 money. So we've got to do something to

1 effect the commercial rates.

2 I have a proposal that I'm trying to
3 put forward here today, and I want to
4 continue to work with you on this after
5 this meeting, and it has to do with the
6 subsidization of private health insurance
7 rates because of public payers, public
8 purchasers of health, Medicaid,
9 Commonwealth Care. These -- this has
10 been a constant theme in Massachusetts
11 over the last decade that the rates of
12 commercial insurance are driven up
13 because the hospitals and providers are
14 effectively subsidizing the rate of
15 public payers, Medicaid and now the
16 connective products, Commonwealth Care.
17 So I have a suggestion of how to deal
18 with this.

19 There have been examples of this
20 method I'm going to describe used in
21 other states for a limited -- in a
22 limited way, and I think we should do it
23 in a very substantial way. And that is
24 to use competitive procurement in

1 Massachusetts to purchase medical
2 services, inpatient, outpatient,
3 laboratory, durable medical equipment,
4 to -- and to undertake a process whereby
5 we would use a procurement methodology to
6 purchase those services for Medicaid both
7 in the MCO portion and the
8 fee-for-service portion and for the
9 connective products. That we would
10 require procurement of health care.

11 I think that this would save hundreds
12 of millions of dollars a year. I think
13 we could save \$100 million this year at a
14 minimum.

15 In order to do this, to use this
16 method, we have to get a -- we would have
17 to get a waiver from the federal
18 government called the "1915 Waiver."
19 These kind of waivers been given out in
20 many states, not exactly for the purpose
21 I'm describing. We already have such a
22 waiver in Massachusetts. We have
23 received a waiver. That's the reason
24 that we were able to have our MCO system

1 in Medicaid.

2 In the purchase of services in the
3 government, we use a bidding system here
4 in Massachusetts, and you know it really
5 works very, very well. The government is
6 able to get good prices on things because
7 its a big purchaser, and the RG's office
8 is right in the middle of overseeing
9 public purchasing. So every day, every
10 day of the year, we're involved with
11 looking at the procurement of goods and
12 services and the government.

13 The best way to procure services from
14 a procurement point of view is a two-part
15 process. First part, pre-qualification
16 of the bidders. In this case, it would
17 be, for example, hospitals who wish to
18 provide, for example, ordinary childbirth
19 services.

20 This would be a carve out in a bid
21 where the end result would be -- or
22 the -- be -- first step would be the
23 Commonwealth would set rigorous standards
24 for quality, and only those facilities

1 who meet those standards for quality
2 would be allowed to bid. But once they
3 meet those standards, the competition is
4 price based. That is the gold standard
5 of success in government bidding. The
6 best way to get a good deal. That is
7 what I'm suggesting we do.

8 The peculiarities of the way that
9 Massachusetts pays for Medicaid and
10 Commonwealth care represents a handcuff
11 that we put on ourselves that drives our
12 costs up unnecessarily. And the reason
13 that we have that handcuff on is that we
14 put it on ourselves, and there's no
15 reason for it. We have to harness the
16 power of competitive procurement to get a
17 good deal. It works everywhere; it will
18 work here.

19 I'll give it a practical example.
20 Because of the way Medicaid pays for
21 inpatient stays under the standard
22 payment amount per discharge, it's called
23 "SPAD," every hospital has a payment, a
24 standard payment for anybody who stays at

1 that hospital for either one day, up to
2 20 days. For example, the SPAD rate for
3 some of the teaching hospitals could be
4 10,000, 11,000 or even more per day,
5 per -- per admission. So if somebody
6 goes to a teaching hospital to have a
7 baby, the Commonwealth is going to pay
8 \$11,000 for that. If they go to Norwood
9 Caritas, they'll pay \$4,500 for that.

10 If -- if this were a competitive
11 procurement situation, the government,
12 and somebody came to me -- to the IG's
13 office and said, "We're purchasing
14 services," and the low cost, qualified
15 bidder is being bypassed and the business
16 is going to the high bidder, we'd call
17 the Attorney General's Office. But it
18 falls in the category if there were a law
19 against this, you'd be breaking it right
20 now, but there's not, but there should
21 be. We should be purchasing services by
22 competitive procurement, and I think we
23 can.

24 Massachusetts is very, very unusual

1 in the history of our country. The
2 opportunity for us to do this is unique
3 because of the facts that have been
4 brought forth by the most recent Attorney
5 General's report, by Attorney General
6 Martha Coakley. That's a critically
7 important document in history.

8 And by the findings and work of the
9 Division of Insurance and the hearings
10 that are underway and some of the facts
11 that have been brought out, we have an
12 unusual situation in Massachusetts. That
13 is, we have very -- a preponderance of
14 very expensive providers, teaching
15 hospitals, physician's groups affiliated
16 with teaching hospitals that have reached
17 out to the community and as a result of
18 this, there's huge disparities in the
19 costs.

20 Now, under the Social Security Act
21 that created Medicaid and under which
22 Medicaid is authorized, there's a
23 principle that every eligible recipient
24 has the right to go to every eligible

1 provider; free access is the idea. My --
2 this -- this waiver that I suggest that
3 we would expand is a -- is the waiver
4 that allows a state to limit that for
5 various reasons.

6 So we apply for a waiver to the
7 federal government to have patients who
8 are participating in the MCOs to have a
9 relative limited network that -- that
10 required an exception. So my -- my
11 suggestion is we do what other states
12 have done -- some other states have done,
13 but which I think would be highly
14 successful here. That is we would
15 competitively procure services that are
16 susceptible to big differences and
17 savings, and I would recommend that you
18 would consider this as part of your
19 current deliberations because it would
20 help to ameliorate the issue of the
21 subsidization by public payers in
22 Massachusetts.

23 In other words, I believe that for a
24 great percentage of -- of the business

1 that Medicaid provides, that we would be
2 able to -- to purchase it at much less
3 but yet at high quality.

4 And let me finish by -- by citing
5 some testimony that was educed by
6 Commissioner David Morales during his
7 recent ongoing work in trying to find
8 ways to save money in our system, and it
9 was testimony presented to him on
10 March 5th by Network Health. And I -- I
11 urge every person who is following this
12 debate to read this submission that's
13 available online by Christina Severin,
14 president of Network Health, in which she
15 lays out on behalf of a very, very, very
16 good organization, the reasons why
17 they're handcuffed in the operation of
18 Medicaid.

19 And if you read that in -- in the --
20 in the light of what I'm talking about, I
21 think there's a way for us to take
22 advantage and reduce our costs
23 significantly by having patients, our
24 patients, go to high quality but less

1 expensive facilities, and they would --
2 and we would say that's where you go.
3 This -- this is the -- this is the set
4 which the -- a physician, your physician,
5 can send you.

6 The comment that is made by Christina
7 Severin, the president of Network Health,
8 concerns the fact that patients are --
9 have freedom of choice to go to any
10 facility. Physicians have freedom of
11 choice to send to any facility, and a
12 great preponderance of their care is sent
13 to expensive facilities beyond the
14 control of the MCO, beyond the control of
15 Medicaid, and there's a way to avoid that
16 and I think we should, and I think it
17 would be very lucrative and valuable
18 without a diminution in quality.

19 Thank you very much for all the time
20 listening to me, and congratulations on
21 your work, Commissioner, and also Tom
22 O'Brien and -- on behalf of my office to
23 Attorney General Coakley for all the
24 great work that your office did on -- on

1 your recent two reports. Thanks.

2 MR. MORALES: Inspector General,
3 thank you so much for your -- your
4 comments. We will definitely take into
5 consideration your ideas. I appreciate
6 that.

7 So let's start with the public
8 component of the hearing. What I will do
9 is call each individual and every
10 individual I call, please come to the
11 podium, offer your testimonies. I'll
12 respectfully ask you to keep it to three
13 to five minutes.

14 Amy Kline.

15 AMY KLINE: Good afternoon and -- and
16 thank you. As the commissioner said, my
17 name is Dr. Amy Kline and I am
18 representing the American Physical
19 Therapy Association of Massachusetts. I
20 am a member of the APTA, American
21 Physical Therapy Board of Directors, our
22 main -- national, as well as a clinical
23 assistant professor at the MGH Institute
24 of Health Professions here in Boston.

1 The American Physical Therapy
2 Association in Massachusetts represents
3 the Physical Therapy Association of the
4 Commonwealth, and our members practice
5 across a spectrum of healthcare delivery
6 settings. We support the imperative need
7 for the healthcare cost reform in
8 Massachusetts and look forward to working
9 with the administration and the
10 legislator on appropriate reforms to slow
11 the rise in healthcare costs while
12 preserving access to care and the
13 communities ability to choose their own
14 healthcare providers.

15 We urge caution with any large scale
16 refirms -- excuse me -- reforms, as a
17 potential for unintended consequences is
18 great. Some proposals have the real
19 potential to force small providers out of
20 business. We urge consideration of pilot
21 programs, which can uncover unintended
22 consequences before a large real-time
23 deployment.

24 Many of our members practice in

1 settings of 50 or less employees. Thus
2 our members are being squeezed from all
3 sides in the current healthcare
4 environment. Our members face double
5 digit insurance -- insurance premiums,
6 increases annually and have seen payments
7 for our services from insurance
8 companies, especially the Commonwealth,
9 decrease relative to broad-based
10 cost-of-living indicators.

11 Each year, insurers and the
12 government add more unnecessary
13 administrative burden. For example, most
14 payers have their own documentation
15 system and process to request approval
16 for treatment. Cost of utilities,
17 payroll, benefits, insurance and all
18 other associated costs with operating a
19 physical therapy practice have increased
20 dramatically.

21 To bend the cost curve, the market
22 dominants of healthcare monopolies must
23 be reduced. Small physical therapy and
24 medical practices are the only -- only

1 competition to healthcare monopolies.
2 Without adequate support, there will be
3 no competition. This will reduce access
4 to care and will drive up costs. More
5 small practices will close and be forced
6 to let go many workers across the state.

7 Without adequate safeguards, state --
8 state imposed fee schedules, global
9 payment, capitation schemes will further
10 consolidate the healthcare marketplace.

11 To insure stability in our healthcare
12 service delivery, any state mandated fee
13 schedule, global payment or
14 pseudo-capitation scheme must contain the
15 following safeguards: Allow patients to
16 choose all of their providers, develop
17 and deploy quality measures for hundreds
18 of the most common health conditions and
19 procedures across the spectrum of
20 diseases and injuries.

21 A few metrics for a few or some
22 chronic diseases does not make an
23 alternative contract a valid method of
24 improving broad-based healthcare quality.

1 They must be strict limitations on
2 financial incentives to prevent
3 unwarranted withholding of care.

4 The Commonwealth must closely monitor
5 the hundreds of disease and medical
6 procedure metrics for both over
7 utilization and under utilization. Fee
8 schedules must address prices, insure
9 appropriate access to all services
10 physical therapists offer and daily caps
11 on payment should be removed or raised to
12 insure fees for low-cost providers are
13 not drastically reduced.

14 Physical therapists saved the
15 healthcare system many times over the
16 cost of providing physical therapy. We
17 decrease the need for surgery and
18 imaging. Our successful interventions
19 enable patients to stop using expensive
20 and risky medications.

21 Barriers to accessing physical
22 therapists should be eliminated. These
23 barriers are both administrative and
24 cost. Many insurers in the Commonwealth

1 force patients to needlessly spend money
2 to see their primary care providers in
3 order to access a physical therapist.
4 This has cost and delays access to care.

5 Oftentimes, physical therapists can
6 quickly and inexpensively resolve an
7 injury or condition without the need for
8 other healthcare services. Delays in
9 obtaining physical therapy can complicate
10 recovery and resulting in more lost time
11 from work.

12 The APTA of Mass. supports the small
13 business healthcare insurance group
14 buying -- buying legislation. We believe
15 this will level the playing field and
16 reduce some of the burden on many of our
17 members who own small practices.

18 We support full transparency in
19 healthcare cost and pricing. Consumers
20 should know before their out-of-pocket
21 cost, the cost and services paid by the
22 insurer -- insurers, preferably before
23 the -- excuse me -- before the service is
24 provided. Empowering the consumer with

1 price transparency will facilitate market
2 forces to drive healthcare -- to drive
3 savings.

4 Electronic medical health records
5 should be intra-operable and accessible
6 by all healthcare providers who are
7 caring for a patient regardless of the
8 setting. Limiting access or placing
9 barriers to accessing a patient's medical
10 record by all providers results in poor
11 communication, increased utilization and
12 costs.

13 We look forward to working with the
14 administration and the legislator. Thank
15 you.

16 MR. MORALES: Thank you, Amy.

17 Next we will hear from Judith
18 Rothchild.

19 MS. ROTHCHILD: Good morning. My name is
20 Dr. Judith Shindel Rothchild. I'm an
21 associate professor at Boston College
22 School of Nursing.

23 Testifying on these weighty issues is
24 something I'm very familiar with because

1 I've been doing it since the 1980s,
2 Chapter 372, 574, 23 and in -- when we
3 enacted in December 1991, Chapter 495.

4 I have to comment on a statement I
5 made to the Senate post-audit committee
6 in 1994, when I said, "Competition is a
7 policy which gained prominence due to a
8 lack of will to challenge a republican
9 governor who had enticing economic
10 theories that left weighty decisions
11 about allocating health care to the free
12 market instead of our elected
13 officials -- or elected representatives
14 and public officials. Too much is at
15 stake to sit back and watch the scorpions
16 battle until only one is left.

17 "Massachusetts is a leader in the
18 nation for healthcare services; should be
19 a leader in the nation for innovative
20 healthcare reform. Hopefully, this
21 hearing will begin that process."

22 Well, 16 years later, we have
23 97 percent of our -- our citizens covered
24 through health insurance, and we have the

1 dubious distinction of being one of the
2 priciest healthcare providers in the
3 country.

4 I have specific recommendations based
5 on the AG's report that have relevance
6 for nurses as the biggest providers of
7 health care in the Commonwealth.

8 First, and I've talked to the
9 commissioner about this, of the -- the
10 conclusion that prices paid to hospitals
11 are not based on the complexity or acuity
12 of care. We, in nursing, firmly believe
13 that DRGs need to be adjusted to include
14 nursing intensity weights. New York
15 State has such a system in place. It is
16 my belief that that could account for
17 about 13 percent of the variance, not 190
18 percent, but that's at least a step in
19 the right direction.

20 One way of collecting that
21 information that nursing is working on
22 right now is to use an electronic medical
23 record to -- to collect real-time nursing
24 intensity information on a

1 patient-by-patient basis. I think that's
2 an exciting, easy to administer
3 alternative.

4 The fact that there's no correlation
5 between price and quality, and I really
6 think that the hearings lacked an
7 emphasis on quality and how are we going
8 to measure quality. There's been a lot
9 of focus on price. We have to have and
10 expand that discussion on quality.

11 Nursing has done a lot of work on
12 nurse sensitive quality measures. In the
13 hearing yesterday, one of the hospital
14 administrators said, "Can we please pare
15 this down to just 15 that we can all
16 agree with?" I'm actually very
17 sympathetic to that, frankly.

18 I think nursing has contributed to
19 this sort of burgeoning. I may be alone
20 in this, of quality measures, but I'd
21 like to talk to you about some key
22 nursing quality measures, like failure to
23 rescue, sepsis and RN to patient
24 staffing. That's easy for patients and

1 payers to understand. In the CCU, for
2 24 hours, every nurse is, on average,
3 assigned 1.4 patients. That's simple and
4 straightforward.

5 The prices paid to the networks that
6 vary. I have spent the last two weeks
7 since I knew I would be testifying here
8 crunching information, looking at does
9 nurses -- do nursing -- does it have any
10 role in this variation at all? I
11 couldn't find anything that related
12 nurses' wages to what hospitals -- total
13 hospital charges were or total hospital
14 charges for separate medical procedures.

15 There were some other significant
16 findings that I think are worth pursuing.
17 Profit is tied to nursing wages; teaching
18 status is tied to nursing wages. We've
19 heard a lot about teaching burden,
20 especially from Dr. Stu Altman, and we
21 need to tease that out.

22 In summary, multiple commentators in
23 these hearings have noted that market and
24 regulatory costs containment reforms need

1 not be mutually exclusively. I agree.
2 Essential healthcare services should not
3 be left to the whims of the free market,
4 nor can regulation alone, and I think
5 this is very important, properly align
6 cost and quality. We have to have a
7 discussion that balances those two
8 interests.

9 Registered nurses are the largest
10 group of healthcare providers in the
11 Commonwealth. We have a very important
12 critical role in identifying reforms for
13 both universal access to high-quality,
14 cost-effective care.

15 Thank you, and I submitted my
16 comments and supporting documents by
17 e-mail.

18 MR. MORALES: Thank you, Judith,
19 appreciate that.

20 Next, Carol Allen.

21 MS. ALLEN: Good afternoon, Commissioner
22 Morales, and Mr. O'Brien. Thank you for
23 allowing me to speak today.

24 I'm Dr. Carol Allen. Excuse my frog

1 in my throat. I'm Dr. Carol Allen,
2 president of the Massachusetts Chapter of
3 the American Academy of Pediatrics,
4 speaking on behalf of our 1700
5 pediatricians across the Commonwealth.

6 Our chapter and the American Academy
7 of Pediatrics know the most effective and
8 most efficient care for children is that
9 offered through the medical home.
10 Indeed, our chapter has developed a white
11 paper on the pediatric medical home,
12 which I will submit to you
13 electronically.

14 A well-trained and experienced
15 pediatrician practicing with a strong
16 support team and partnering with
17 patient's and parents to provide high
18 quality and cost-effective care, because
19 it is -- will provide high quality and
20 cost-effective care because it is built
21 upon a relationship of trust.

22 All payment mechanisms should
23 reinforce and strengthen these
24 relationships and shore up the foundation

1 of the primary-care practice. We've
2 heard a lot about hospital-based
3 medicine, but their primary care is where
4 most patients get their care.

5 Care management is at the heart of
6 the medical home. Payments need to be
7 adequate to provide support for care --
8 care management in the primary-care
9 setting.

10 It should facilitate coordination of
11 complex medical, social, family support
12 and developmental needs, assess problems
13 such as obesity, asthma, attention
14 deficit and developmental needs and
15 behavioral issues and cover the full
16 range of preventive services that
17 currently form the core of pediatric
18 practice.

19 For pediatric patients, especially
20 those with complex conditions, the
21 payment system must also assure access to
22 pediatric specialists and programs of
23 demonstrated value, such as early
24 intervention, must be supported and

1 strengthened. Right now, there's a
2 threat to cut back on early intervention.

3 As you know, most chronic diseases,
4 heart disease, stroke and hypertension
5 and diabetes have their origins in
6 childhood, yet many insurers don't offer
7 incentives to manage their precursors
8 such as obesity, which has become an
9 epidemic.

10 High-quality care for children
11 provided through the medical home is
12 inexpensive and improves outcomes.
13 Indeed, investment in the health of young
14 children is the best investment we, as a
15 society, can make for a self -- for a
16 safe and affordable future.

17 An ounce of prevention is worth a
18 pound of cure. You've heard that, but it
19 really is important to invest in
20 prevention, including things like oral
21 health and vaccines, and to maintain the
22 strong public health support system.

23 Our chapter has worked closely with
24 the Mass. Department of Public Health on

1 obesity prevention and prevention of
2 smoking and exposure to second-hand
3 smoke.

4 We depend upon DPH to provide our
5 vaccines and to give us regulations
6 around their use, and we think that if
7 you revamp payment systems but
8 shortchange public health investments,
9 that would be foolish and shortsighted.

10 To contain long-term cost -- costs,
11 it's also important to invest in
12 infrastructure for health IT so that
13 systems and providers can communicate
14 with each other. This would reduce
15 duplication, which is a huge source of
16 inefficiency in health care. Most --
17 most the HR systems aren't designed
18 around the needs of pediatric patients.

19 While the Recovery Act provides funds
20 to states to help with meaningful use of
21 the HR implementation, a practice has to
22 meet a threshold of 20 to 30 percent
23 Medicaid population to qualify for the
24 funds. Many Massachusetts pediatric

1 practices would not meet this threshold.

2 To the extent possible, the
3 Commonwealth should leverage the funds
4 that are provided for meaningful use to
5 establish supports that are available to
6 all providers who care for children.

7 And because the mind and the body are
8 tightly connected, our systems need to
9 support collaboration between primary
10 care and behavioral health providers.

11 Coverage for effective behavioral
12 health management is likely, ultimately,
13 to payoff in improved outcomes and reduce
14 overuse of doctor's offices and emergency
15 rooms.

16 There needs to be support for
17 families in crisis and for medications
18 when indicated. The MedPAC program that
19 offers immediate psychiatric consultation
20 to primary-care pediatric practices is a
21 wonderful example of cost-effective
22 acute-care management. This program,
23 currently being downsized, should be
24 supported or even expanded. And I want

1 to say, "Personally, I think that
2 medal -- mental health carve outs are a
3 mistake and there really ought to --
4 somebody ought to rethink that whole
5 system."

6 Finally, regarding global payments
7 and accountable care organizations, our
8 chapter urges that caution be used.
9 Hospital systems and primary-care
10 practices often have conflicting
11 incentives so it makes a difference who
12 is the primary recipient of the funds.

13 I believe, and I work for Harvard
14 Vanguard, that's my disclosure, that the
15 distribution directly to a provider
16 system has a better chance of resulting
17 both lower cost and healthier patients
18 than if it's distributed by way of the
19 hospital.

20 But in dealing with small practices,
21 the devil will be in the details. They
22 cannot be arbitrarily grouped, and they
23 may fair poorly if they're aligned with
24 hospital systems. So it's important to

1 keep the patient clearly in mind when
2 designing these systems. The incentives
3 must be around collaboration, innovation
4 and patient centeredness, ideally,
5 provided in the context of the medical
6 home.

7 I'm happy to answer questions, if you
8 have any. Thank you.

9 MR. MORALES: Thank you, Doctor.

10 Robert Simmons.

11 MR. SIMMONS: Hi. Thank you for your
12 time, Commissioner, Ms. Murray.

13 My name is Bob Simmons. I'm the
14 vice-president and coowner of Boston Home
15 Infusion. I'm also a registered nurse
16 and a registered therapist.

17 When we started the company 18 years
18 ago, we started the company servicing a
19 population that no other provider would
20 service in the Commonwealth at the time.
21 Even companies that I was employed by,
22 which were nationally owned providers,
23 and that population was the Mass. Health
24 population. We serviced communities

1 throughout the Commonwealth, anywhere
2 from Pittsfield to New Bedford, all the
3 way up at Lowell and Lawrence.

4 So as a company, what we've attempted
5 to do is, is to keep the clients at home.
6 And this is a problem that I somewhat
7 have. As a matter of fact, sometimes I
8 think we should change our name to Boston
9 Home Infusion Medical Center. Because,
10 basically, we are a hospital without
11 walls.

12 We employ pharmacists, nurses,
13 therapists, dieticians, all the
14 components to care for the clients
15 outside the facility. Other than
16 surgery, there's not much that we cannot
17 do in the home, which is the most
18 cost-effective platform around.

19 So I -- I really have a hard time
20 understanding why this particular side of
21 our -- of our health care is not being
22 strongly looked at and evaluated, but
23 instead is kind of like on the chopping
24 block. Continually cutting the home

1 healthcare side, medical equipment and/or
2 services, things like that, is
3 detrimental to health care.

4 When I tell you the fact of simple
5 things like providing oxygen to a client
6 at home is less than \$10 a day, where in
7 the facility, it's like \$6,000 on a
8 short-term stay. IV antibiotics at home,
9 anywhere from \$150 to \$200 per day as
10 compared to 1,500 to \$2,500 a day. Now,
11 call me "crazy," but I don't think you
12 have to be a rocket scientist to figure
13 out and -- and work the math.

14 As Ellen -- Ellen Zane said, "You
15 know what? Low-cost providers continue
16 to get persecuted," and we are a low-cost
17 provider in this industry and we continue
18 to get persecuted. We have to main --
19 maintain credentialing, joint commission
20 status, all of the requirements like any
21 other institution.

22 So my last comments, without wasting
23 a lot of time, I don't want to be
24 repetitive, is that we need to reduce

1 disparities. We need to reinvest in the
2 home healthcare product or model, and I'm
3 more than energetic and willing to work
4 with anybody and the commission to help
5 because I think there's a -- it's a
6 value-added service to reducing our
7 healthcare costs.

8 Thank you very much.

9 MR. MORALES: Thank you, Mr. Simmons.
10 David Matteodo.

11 MR. MATTEODO: Thank you, Commissioner,
12 for this opportunity to offer some
13 comments.

14 My name is David Matteodo, and I'm
15 the executive director of the
16 Massachusetts Association of Behavioral
17 Health Systems, which is an organization
18 of 47 psychiatric and substance abuse
19 hospitals throughout Massachusetts, and I
20 appreciate this opportunity to give some
21 comments. I've heard a few references
22 today to be -- mental health, and that's
23 great, Dr. Gottlieb, and one of the
24 previous speakers. But I'll just give

1 you a little framework as you kind of
2 approach payment reform and how the --
3 how we see the mental health and the
4 behavioral health system fitting in.

5 Basically, in Massachusetts, there's
6 about 2,500 private beds in -- in my
7 system. There's about 650 DMH state
8 beds, so all together we are talking a
9 little bit over 3,000 beds.

10 Our hospitals in the -- in the
11 private sector are very heavily public
12 payer dependent; we're between 60 and 70
13 percent Medicaid and Medicare. So the
14 government is a huge payer. Our average
15 length of stay is about 8 days, and we
16 generally run about 80 to 90 percent
17 occupancy.

18 The -- in the last couple of years,
19 we've lost -- we're in the process of
20 losing one of the child units. Some
21 adult beds have closed, not a huge
22 amount, however, surprisingly, we've four
23 Geri psychiatric units open and we've had
24 one child unit expand. So we're kind of

1 holding our own. But it's extremely
2 fragile, and the DMH now has closed -- to
3 get down to the 650 beds, they will have
4 closed 150 beds in -- in the last eight
5 months. So it's a very fragile system.

6 Our system, we believe, is
7 underserved, under funded and, really,
8 over managed. We have -- the state has
9 done, through the Mass. Behavior Health
10 Partnership in the last few years, two
11 independent analysis that show a gap of
12 between 20 and 30 percent between our
13 costs and our actual payments. So we're
14 under -- we're under -- underpaid.

15 We're also very -- ironically, very
16 heavily managed. There's carve outs.
17 There's insurance companies. Our --
18 our -- we need preauthorization. We need
19 concurrent reviews on a regular basis, so
20 it's very heavily micromanaged.

21 And we have to fight for equity.
22 We -- we just recently had a parity bill
23 passed, which is great, but there's still
24 our problems. Medical records is one,

1 the stimulus bill that passed Congress
2 earlier contains no money for behavioral
3 health providers, just acute care and --
4 and doctors.

5 So what do we see in -- in this for
6 you all that I would recommend? There's
7 real opportunities here. The lack of
8 integration between behavior health and
9 physical health. There's real
10 opportunity, the MedPAC program was
11 mentioned earlier. We need more programs
12 like that. The other thing that's very
13 important to address this is because the
14 mentally ill, the severe mentally ill,
15 have a life expectancy of 20 years less
16 than the average population. Obesity,
17 diabetes, heart disease, numerous
18 problems, if we can get the mentally
19 ill -- not only mentally, deal with their
20 mental situations but also their
21 physical, it will save the state and
22 the -- and the private sector a lot of
23 money. So we think there should be --
24 I've heard some great ideas, lower

1 administrative costs in the behavioral
2 health system, give us some incentive to
3 share the savings. If we -- if we can --
4 you know, there were ideas mentioned
5 about holding providers harmless and then
6 if they save they could share it with the
7 insurers. Ideas like that, I would think
8 are -- are excellent.

9 And to sum up, we really think if
10 there is a global payment system, that we
11 should -- that behavior health needs to
12 be part of it. We want to be carved in,
13 not carved out, and we think that there
14 needs to be sufficient behavioral health
15 networks. I think we're moving as a
16 country and as a state, certainly, in the
17 last ten years, very, very far along in
18 this area. We just need to keep it up.

19 So, thank you. I can write this --
20 is there -- is -- I meant to ask. Is
21 there a time period for comments?

22 Because I can write this up for you.

23 MR. MORALES: Yes, the 29th.

24 MR. MATTEODO: The 29th, great.

1 MR. MORALES: 26th. No, the 26th.

2 MR. MATTEODO: Thank you.

3 MR. MORALES: Thank you, Mr. Matteodo,
4 appreciate it.

5 Next up, Karen Estrella.

6 MS. ESTRELLA: Good afternoon,
7 Commissioner. Thank you for the
8 opportunity to testify today. It's
9 interesting listening to some of the
10 other organizations and the similarities
11 that we -- that we all have.

12 My name is Karen Estrella, and I am
13 the executive director of the New England
14 Medical Equipment Dealers Association.
15 Our members in -- we're a 68 association
16 and our members provide durable medical
17 equipment, home oxygen therapy, home
18 infusion therapy and custom wheelchairs
19 in the six New England states.

20 Our members are also heavily
21 dependent on Medicare and Medicaid.
22 Those are the two biggest payers for our
23 members as well. And our industry is
24 similar to some other groups that spoke,

1 heavily regulated, intense document
2 requirements. And then at the same time,
3 we've been having numerous reimbursement
4 cuts over -- you know, over the years
5 from -- from all -- from all payers
6 actually, but yet we know that home
7 medical equipment and the services that
8 our members provide are the most cost
9 efficient way to take care of patients.

10 CMS administrators have touted the
11 value of home care over the years. It's
12 where patients prefer to be treated and
13 it is the most cost-effective delivery of
14 health care.

15 Some of the things I heard from the
16 panel today that were interesting was
17 that they wanted to see a more
18 encompassing system. They wanted to see
19 quality standards. It was interesting to
20 hear one of the speakers talk about that
21 there's too much care in expensive
22 settings, and, again, that's where we
23 feel our industry is -- will bring value
24 to this discussion.

1 And I'll have to tell you, that we're
2 an industry that's not well understood.
3 I think a lot of people think we just
4 drop off oxygen concentrators like the
5 pizza delivery guy and that's it, but yet
6 our members are hiring nurses,
7 respiratory therapists, clinicians.
8 They're in the patient's home. They're
9 sometimes the eyes and ears of the doctor
10 in the -- in the patient's homes for
11 them.

12 But we haven't done a good job of
13 being out there in -- in the public so
14 that's why we're here today, part of the
15 reason. And we are the smallest piece of
16 the healthcare pie, but the return on
17 investment, if you invest in our
18 industry, is really, really huge.

19 And before I end, I -- so I'd -- we
20 would like to work with you,
21 Commissioner. We're looking forward to
22 that. But one comment I would like to
23 make with respect to some of the comments
24 from the Inspector General's office about

1 competitive bidding, that is -- that is a
2 concern.

3 I understand that his thoughts are
4 well intended, but they're having several
5 economic studies on the negative
6 consequences of competitive bidding for
7 durable medical equipment industry, and I
8 will provide those to you, Commissioner,
9 for your review. That -- we believe that
10 there's other ways that we can find
11 savings and -- and contain costs than --
12 than going to competitive bidding. At
13 least I can speak that for -- you know,
14 for our industry.

15 Again, thank you for the opportunity
16 today.

17 MR. MORALES: Thank you, Karen.

18 Next, Julie Lynch.

19 MS. LYNCH: Good afternoon. Thank you
20 for this panel and for the opportunity to
21 offer comments.

22 I'm offering testimony as an
23 individual who's a nurse, a Ph.D. student
24 researcher at U. Mass. Boston and as a

1 family member of a cancer patient who has
2 benefited substantially from the superior
3 quality of cancer care offered by Boston
4 area Comprehensive Cancer Center.

5 I have two main concerns about the
6 discussions that have taken place over
7 the last three days. Measures of quality
8 in health care, particularly for terminal
9 conditions that rely on cutting-edge
10 clinical research are limited and
11 therefore cannot be adequately linked to
12 costs.

13 Patients can't always nor should
14 always be held responsible for their
15 health conditions. For anyone who has
16 studied social determinants of health,
17 the relationship between environmental
18 conditions and the ability to live a
19 healthy lifestyle is apparent.

20 I will first discuss measures of
21 quality. As Andrew Dreyfus mentioned
22 yesterday, we do not have good,
23 well-defined measures of quality,
24 particularly in cancer care. I'm on the

1 health equity committee at Comprehensive
2 Cancer Center, and this is an issue we
3 have struggled with in the development of
4 our health equity report. While I'm
5 confident that our community hospitals
6 offer equal, if not superior care for
7 certain conditions and procedures, I know
8 through personal experience and
9 professional research for some cancers,
10 the evidence clearly demonstrates that
11 care in a Comprehensive Cancer Center is
12 superior.

13 In Massachusetts, 40 percent of
14 African Americans obtain lung cancer care
15 at community hospitals. Community
16 hospitals are not offering lung tumor
17 genotyping services to guide treatment.
18 This is a problem, particularly for after
19 African Americans who are not benefiting
20 from targeted cancer therapies to the
21 same extent whites are and are dieing
22 sooner as a result.

23 Therefore, I believe the relationship
24 between cost and quality has not been

1 fully explicated, and I'm concerned that
2 without good measures of quality, cost
3 pressures will result in an exacerbation
4 of race, ethnic and socioeconomic
5 disparities in healthcare.

6 And I want to address the second
7 point. It is naive to think our
8 healthcare cost problems can be addressed
9 by individuals simply modifying their
10 behaviors. Environmental factors
11 contribute to poor health. Poor and
12 minority neighborhoods do not have access
13 to fresh produce, safe walking or running
14 paths, and these neighborhoods are
15 exposed to significantly more alcohol and
16 tobacco advertisements.

17 Lung cancer is frequently cited as a
18 disease that is due almost exclusively to
19 behavioral choices. This is a good
20 example of an oversimplification. 16,000
21 to 24,000 patients per year in the U.S.
22 who have never smoked die from
23 non-smoking lung cancer. If this were
24 categorized as a separate cancer, it

1 would be among the top ten cancer
2 killers.

3 I sincerely hope that whatever
4 policies the state developed to address
5 rising healthcare costs, they keep these
6 issues in mind.

7 MR. MORALES: Thank you, Julie.

8 Next, Benjamin Day.

9 MR. DAY: Good afternoon everyone who's
10 survived three days of public hearings.

11 My name's Benjamin Day. I'm the
12 executive director of Mass-Care, which is
13 the single-payer healthcare campaign in
14 Massachusetts.

15 We -- obviously, we spent a lot of
16 time trying to win universal single-payer
17 style health care, but we also work on a
18 range of cost control issues that we
19 think will point us in the right
20 direction.

21 Most recently we've been focused on
22 prescription drug costs, which I would
23 note, have been sort of conspicuously
24 absent from these hearings about how to

1 control drug costs.

2 The -- the -- the division's recent
3 report said that drug costs are about
4 20 percent of our total healthcare
5 spending. That's more than we spend on
6 inpatient care, and it's close to what we
7 spend on outpatient care. So I think we
8 are going to have to focus a little bit
9 more on prescription drugs.

10 But just to back up a little bit, I
11 mean, anyone here who's been following
12 the national healthcare debate for the
13 last week or the last year or the last
14 20 years may be despairing that we
15 Americans are not very good at healthcare
16 reform. But there's actually been a lot
17 of states that have passed various
18 sweeping healthcare reform, not just
19 Massachusetts, but Ten Care in Tennessee,
20 the Oregon basic health plan, Wisconsin
21 health rights, Dirigo Health Plan in
22 Maine. These were all actually hailed as
23 universal healthcare bills when they were
24 passed, over a dozen states, but you may

1 not remember them with much clarity
2 because they all failed to control
3 healthcare costs. And with rising
4 healthcare costs, all of their gains
5 covering the uninsured were wiped out
6 between three and five years.

7 I wrote a paper with a couple of
8 Harvard Med School researchers on how
9 these laws have all failed over time
10 because they didn't control costs. So
11 it's not that we're bad at healthcare
12 reform, we're really bad at healthcare
13 cost control, and I think the reason is
14 that we rely on the healthcare industry
15 almost exclusively for job growth and
16 economic growth, and we just can't have
17 our cake and eat it too in this respect.
18 And along with that, you know, that fact
19 makes it very politically difficult to
20 pass healthcare cost controls. But I
21 think it also means that we've passed a
22 lot of cost controls that simply don't
23 work or don't work on a scale that will
24 actually be noticeable to bend the cost

1 curve.

2 We have extensive evidence with rate
3 setting, with chronic disease management,
4 with health IT, with limited networks,
5 capitation, managed care, pay for
6 performance, prior approval of premiums
7 even, managed competition, which was the
8 big thing in the 1990s that didn't work,
9 and there's very -- we -- we tend to pass
10 cost control that is not based in
11 evidence that it will actually work and
12 it will actually get us to -- to a
13 sustainable health care system. And I
14 think we're in danger right now of --
15 of -- of moving towards policy solutions
16 that don't reflect the evidence that
17 we've just got from these two amazing
18 reports.

19 And I think the -- the biggest lesson
20 from these two reports that I took away
21 was that our high and rising healthcare
22 costs are not due to high and growing
23 utilization. It's not because we are
24 using too much care or more and more care;

1 it's because of unit prices that are --
2 that the care we do -- do -- that we do
3 receive costs too much. And yet the
4 primary policy instrument that we've been
5 talking about the last three days, which
6 is moving from fee for service to
7 capitation, is basically designed to
8 reduce utilization.

9 You know, maybe I'm missing something
10 here, but it seems to be off the tracks a
11 bit. And there's very, very little
12 evidence where it's been put into place
13 that switching from fee -- I mean, we all
14 know that our fee-for-service system is
15 broken. We all know that it leads to
16 over utilization, but we also know that
17 it is not the -- it is not the primary
18 driver of our rising healthcare costs,
19 and fixing it is not going to fix our
20 cost problem. And I've listened to quite
21 a few witnesses over the past two days
22 trying to square this circle and it
23 seemed everyone has pretty much said,
24 "Well, we -- we need to do it, but we're

1 going to need to do a lot more than
2 that." So I think it's the more that's
3 important to focus on right now, and it
4 has -- that -- the more is what has to be
5 evidence based. It has to be what we
6 know has worked in other places in
7 bending the cost curve.

8 And for that, I'm going to quote two
9 other folks who you probably trust more
10 than me, Stephen Sherenbaum, who
11 testified yesterday from the Commonwealth
12 fund. He was asked a question, which is
13 has there been any country in the world
14 that has successfully controlled costs
15 without having a global budget?
16 Essentially, the state budgeting the
17 entire healthcare system, and his -- the
18 answer was no. No state has been able to
19 do it without either a single-payer
20 system or putting a private insurance
21 system under a global budget and heavily
22 regulating insurers.

23 And there was another great paper
24 that was published by Theodore Marmer and

1 Jonathan Oberlander and a couple of
2 others at the outset of this national
3 round of health reform, and it was titled
4 "Obama's Options for Healthcare Cost
5 Control, Hope Versus Reality," and they
6 basically said, "You know, we hate to
7 break this to you, but almost all of the
8 cost control measures you've been
9 proposing have been proven not to work,
10 and pretty much the only option is to
11 have something like a global budget and
12 heavy regulation of the insurance
13 industry as other countries have," which
14 is the same thing that Stephen Sherenbaum
15 said.

16 So, you know, I would just remind us
17 that we have a very short timeline on
18 this. The payment reform proposal has
19 been talked about as our long-term
20 proposal, that it will take five years.
21 Five years takes us to 2015, and if you
22 remember the Len Nichols graph on the
23 first day here, 2016 is when we hit 34 to
24 45 percent of our income, which is

1 unsustainable. So we only really have a
2 very short timeline to get cost control
3 right before we hit healthcare
4 Armageddon.

5 So I -- I really hope that it will be
6 evidence based this time, and I think the
7 bad news, unfortunately, is that we're
8 going to have to do a lot more than is
9 currently politically comfortable to
10 actually get effective cost control that
11 works.

12 So thank you very much for your
13 consideration.

14 MR. MORALES: Thank you, Ben.

15 Eric Linzer.

16 MR. LINZER: Good afternoon, Commissioner
17 Morales, Division Chief O'Brien. Thank
18 you for the opportunity to testify this
19 afternoon.

20 For the record, my name is Eric
21 Linzer. I'm the senior vice president
22 for Public Affairs and Operations for the
23 Massachusetts Association of Health
24 Plans. We're a nonprofit trade

1 association that represents 11 health
2 plans that operate in the state. We
3 appreciate the opportunity to testify, in
4 particular because we were strong and
5 early supporters of these hearings and
6 the reports that have come out. We
7 commend you, both your offices and the
8 work of your staffs in terms of putting
9 this information out there because we
10 recognize that keeping health care
11 affordable is the challenge facing all of
12 us in health care.

13 But the other piece to remember is
14 that health insurance premiums and
15 medical costs are inextricably linked.
16 As these reports have indicated, the
17 major contributing factor to the
18 increases in premiums have been the
19 rising cost of medical services charged
20 by providers. As has been noted, the
21 bulk of premium dollars, nearly \$.90 on
22 the dollar, pays for medical services
23 such as doctor's visits, prescription
24 drug coverage, hospital stays and other

1 services that benefit consumers.

2 So while utilization has been a
3 contributing factor, the major factor has
4 been the price of services. So any
5 serious discussion about keeping health
6 care affordable needs to start with what
7 we pay for care.

8 As your offices start to think about
9 and turning your attention towards
10 solutions for making healthcare
11 affordable, we'd like to offer five
12 steps, both short term and long term
13 approaches, to include in the final
14 report.

15 First, is passing the affordable
16 health plan. House Bill 4452 filed by
17 Representative Harriet Stanley and
18 Senator Richard Moore would provide small
19 businesses with significant rate relief.

20 It does three thing. First, it sets
21 a standard benefit product consistent
22 with the Commonwealth Choice bronze level
23 product.

24 Second, it limits reimbursements to

1 providers for this one product, no more
2 than 10 percent above Medicare, and,
3 third, it would cap health insurance
4 profits to no more than 2 percent for all
5 small products offered in the small and
6 non-group markets.

7 Taken together, this would reduce
8 premiums for individuals and small
9 businesses by as much as 22 percent. But
10 in addition to that, it would also
11 provide a -- you know, address some of
12 the market challenge issues that folks
13 have talked about earlier today.

14 Two other -- two other pieces, and
15 we'll provide the remainder with our
16 written comments, is that we think that
17 there needs to be a statewide healthcare
18 planning process. As has been discussed
19 over the last couple of days, the medical
20 arms race has contributed to both
21 increased utilization but also increased
22 prices, and we think that going forward
23 that one of the recommendations should be
24 that there should be a planning process

1 to coordinate both the availability of
2 services but also where these services
3 are provided so that as was discussed
4 yesterday, we eliminate some of the
5 duplication of existing services that
6 ultimately lead to increased costs.

7 And, finally, with regard to payment
8 reform, while we support payment reform
9 and recognize that there -- there are
10 challenges in terms of getting to where
11 we want to be in the next five years, we
12 think the state could begin this process
13 by outlining a series of recommendations
14 that set clear performance goals and
15 benchmarks for reducing state per capita
16 healthcare costs to no more than the
17 national average and outlining measures
18 to ensure the payment reform does not
19 lead to higher prices and further
20 provider consolidation.

21 We appreciate the opportunity to
22 testify today and be happy to take any
23 questions. Thank you.

24 MR. MORALES: Unless there are any other

1 folks that want to testify, we'll move on
2 promptly to Assistant Attorney Tom
3 O'Brien, who will conduct two
4 examinations. This is Mr. O'Brien.

5 MR. O'BRIEN: Thank you, Commissioner
6 Morales, and thank members of the public
7 who testified.

8 At this time, I would call Paul Levy
9 forward and ask that he be sworn in for
10 examination.

11 I'm going to move around to your side
12 of the table, Paul.

13 BY MR. O'BRIEN:

14 Q. You understand that you do remain under oath?

15 A. Yes.

16 Q. And were there any conflicts or other types of
17 limitations that you wanted to note for the
18 record?

19 A. There are none.

20 Q. There are none. Thank you.

21 Before we begin, I just wanted to, again,
22 thank Commissioner Morales for the scheduling
23 of these hearings and for the legislator for
24 setting up the opportunity to evaluate the

1 healthcare marketplace cost trends and cost
2 drivers.

3 On behalf of the Office of the Attorney
4 General, I want to thank the payers and
5 providers who provided information, two of whom
6 I will examine this afternoon from Tufts
7 Medical Center and from Beth Israel, with
8 regard to the information that we reviewed.

9 What my -- the approach we'll take, and,
10 hopefully, it will help illuminate some of the
11 things that we have heard already, but to have
12 experts in the field look at some of the issues
13 that have been found both in the Attorney
14 General's report and the Division of Healthcare
15 Finance and Policy's report in a linear way.
16 And, hopefully, it will help expand upon some
17 of the comments that -- that we have heard both
18 through the experts but also some of the
19 important comments that we heard from
20 Julie Lynch just a little while ago on social
21 determinants of health, some of the comments we
22 received on behavioral health and the issue
23 with regard to home health as part of a broad
24 discussion to look at cost trends as we go

1 forward. So to the extent that you can keep
2 those in mind, I think it will be helpful to
3 this examination to be a useful process.

4 So, I begin with my first question, which
5 is just for identification purposes. State
6 your name and a bit about your background, for
7 the record?

8 A. My name is Paul Levy. I'm president and CEO of
9 Beth Israel Deaconess Medical Center. I've
10 been in this position since January of 2002.

11 Before that, I served a number of positions
12 in both the private and public sector. I think
13 the one that might be helpful and -- and
14 relevant here is for several years, I was
15 chairman of the Department of Public Utilities
16 in Massachusetts and, therefore, served in a
17 regulatory role with regard to rates and -- and
18 conditions of service of electric utilities and
19 regulated common carriers in the State of
20 Massachusetts.

21 Q. Before we go on, just a follow up on that last
22 comment. If you could, just based on that
23 experience, indicate what is a utility and why
24 is it regulated?

1 A. Well, generally, the economic theory that --
2 that arises behind regulation of utility
3 companies is that utilities became regulated by
4 the state governments for several reasons, one
5 of which, which does not apply in this case,
6 but as I will suggest is not so important one,
7 is that the utilities were granted guaranteed
8 franchise area to -- to serve.

9 The others were that they provided an
10 essential public service, that they were
11 capital intensive and, therefore, required an
12 assurance of a return of capital and a return
13 on capital for long lived assets.

14 Another was that there was a public
15 expectation that the pricing of electric
16 utility services and natural gas services, for
17 example, would be nondiscriminatory, that it
18 would not be based on the market power of
19 consumers, their status in society or other
20 factors not having to do with their underlying
21 of use and cost characteristics so that
22 nondiscrimination of pricing was deemed to be
23 in the -- in the public good, all those things
24 together. And there are probably other factors

1 now that I'm -- I'm forgetting about.
2 Motivated state legislators -- legislatures
3 throughout the United States in the early
4 1900s, to create public utility commissions, to
5 regulate those utility companies, establishing
6 what is now called "a social contract" where
7 the utilities had an obligation to serve at
8 certain levels of quality. In return for that,
9 they would have a reasonable opportunity to
10 earn a good return on investment, and the
11 balancing of that -- of those various interests
12 would be carried out by a quasi judicial body
13 operating under principles of administrative
14 law subject to judicial review generally
15 appointed by a governor but sometimes elected
16 by the population. So in a nutshell, that's
17 what public utility regulation is about.

18 Common carrier regulation is similar in
19 nature, although unlike public utilities with
20 guaranteed franchise areas, common carriers
21 tended to provide a service. For example, the
22 telephone company and -- and, indeed, trucks
23 and busses at one point in our lives, were,
24 likewise, regulated for similar reasons.

1 Q. And if I -- just building on that, obviously,
2 the Commonwealth has a history of auto
3 insurance regulation, which as I -- which is it
4 born out from the same type of factors or is it
5 a mandatory obligation for consumers to have
6 the insurance?

7 A. I'm not that familiar with the history of auto
8 insurance regulation, and over the years I've
9 had trouble understanding it as -- as a driver,
10 but I'm sure there are similar elements. That
11 is to say what amounted to an essential public
12 service because of a requirement for people to
13 have -- to have insurance, a desire on the part
14 of legislators and governors to balance the
15 rather small purchasing power of individual
16 customers against the larger selling power
17 of -- of larger insurance companies and having
18 participated in some of the auto rate hearings
19 over the years as an expert witness setting up
20 a similar quasi judicial function to review the
21 reasonableness of rates and having that subject
22 to judicial review.

23 Q. And just if there are a corollary between
24 that -- those markets and either the health

1 insurer marketplace or the provider
2 marketplace? And when I say "provider," I'm
3 talking about -- I'd ask you to focus on larger
4 licensed health centers and hospitals.

5 A. I've come to believe that there is an analogy
6 to be made. It's not a perfect analogy,
7 admittedly, and that hospitals and physician
8 groups don't have guaranteed franchise areas,
9 but they do have geographic areas in which they
10 are most likely to efficiently operate. And in
11 some cases, as we've seen as the evidence has
12 been presented in -- in this set of hearings,
13 providers, which is to say "hospitals and
14 physician groups," can essentially serve in a
15 monopoly kind of role for at least a portion of
16 the spectrum of care.

17 You might have an isolated hospital, for
18 example, in the -- in a town in western
19 Massachusetts or southeastern Massachusetts
20 that has an essential monopoly with regard to
21 secondary care, although patients might be
22 transported to a tertiary center for the -- for
23 secondary care. That would be, clearly, a
24 geographical likelihood that they would

1 provide -- get their care locally. Likewise,
2 people seeing their physicians, their primary
3 care and local speciality care, may face what
4 amounts to a monopoly.

5 And then in the -- in the bigger
6 Metropolitan area, the Boston area in
7 particular, we've seen how there's a difference
8 in market power and dominance of -- of provider
9 groups, even in the Metropolitan area. And
10 although they don't have a monopoly, there is
11 clear market power. And what I would suggest
12 is what congress call "a lack of
13 contestability" where the business of taking
14 care of patients in those tertiary centers, and
15 for that, you have to look at the underlying
16 structure of the industry, which is that the
17 tertiary hospitals are, referral centers. They
18 receive their patients, for the most part, not
19 exclusively but for the most part, by the
20 referral network of -- of primary care doctors,
21 specialty -- specialist doctors in the
22 community, community hospitals that have
23 chosen, over time, to affiliate in one way or
24 the other with the major tertiary centers.

1 In the case of the Boston metropolitan
2 area, the larger such system, the partner
3 system builds that affiliation network in great
4 measure through ownership of physician
5 organizations, physician practices and
6 community hospitals, creating a single -- in
7 essence, a single, bottom-line relationship
8 among all of those affiliated participants with
9 the tertiary hospitals. That's a very strong
10 business and commercial incentive for all of
11 the participants in that network who send their
12 patients to that particular tertiary center
13 or -- or to tertiary centers.

14 Other networks -- other hospitals in the
15 Boston area, such as Beth Israel Deaconess
16 Medical Center, and not to speak for -- for
17 others that I don't run, but my impression of
18 Tufts Medical Center, and I know no one's in
19 here so they'll testify later, and Boston
20 Medical Center is that our referral business
21 tends to come from community hospitals and
22 physician groups that we don't necessarily own.
23 We might have some ownership interest. For
24 example, BIDMC actually owns Beth Israel

1 Deaconess Hospital in Needham, but that's the
2 only hospital -- other hospital we own.

3 We do own a number of primary care
4 practices, but many of the referrals we get are
5 not from organizations that -- in which we have
6 an ownership interest. We have relationships
7 based on -- on strategical alliances and
8 clinical practices, but nonetheless which
9 served to in great measure provide referral
10 business to the tertiary center.

11 So if you look at that kind of market
12 structure, while it's different from the public
13 utility structure or the common carrier
14 instructor, you can see that there's a
15 potential and, in fact, I believe the actuality
16 of market dominance in that setting, which then
17 provides what could be viewed as undue market
18 power in the relationship between that dominant
19 provider and the insurance companies with which
20 it negotiates reimbursement rates.

21 I think we heard yesterday from Andrew
22 Dreyfus and I think the day before from Jim
23 Roosevelt, Andrew with Blue Cross Blue Shield,
24 Jim at Tufts, and I had heard previously from

1 Charlie Baker when he was head of Harvard
2 Pilgrim Healthcare, that they basically felt
3 that they did not have sufficient market power
4 to offset the dominant market power of the
5 partners' system in the rate negotiations that
6 would take place.

7 A similar result of things with regard to
8 other providers, vis-a-vis, Blue Cross Blue
9 Shield in the reverse direction. Blue Cross
10 Blue Shield being the dominant insurance
11 company in Massachusetts, having more
12 subscribers than all the other ones put
13 together, as I counted them recently, provides
14 Blue Cross Blue Shield with a dominant,
15 powerful position when we are negotiating with
16 them for our reimbursement rates. And so
17 there's an interesting shift of power,
18 depending which side of the negotiation you're
19 on and which -- which party you are.

20 I was actually a little surprised -- just
21 an opinion, I was a little surprised to hear
22 Andrew Dreyfus yesterday saying that Blue Cross
23 didn't feel they had sufficient market power to
24 withstand partners in a negotiation because

1 I -- from where I had always sat, I viewed them
2 as roughly equivalent in terms of their
3 relative market power, but I -- I believe in
4 what he says when he -- when he says that. In
5 any event, to the extent they don't believe
6 they have sufficient market power to offset
7 partners' market power, they clearly can't
8 exercise such.

9 But the point is we have imperfections in
10 the healthcare marketplace among the major
11 tertiary centers and the major insurers in
12 Massachusetts and, indeed, not only the
13 tertiary centers but the networks affiliated
14 with them, which suggest to me that left alone,
15 the -- the reimbursement setting process, the
16 negotiation process, will fail to produce an
17 economically efficient result. And I believe
18 the data collected by the Attorney General's
19 office and the -- the data collected by the
20 division in -- by -- and the witness testimony
21 in this proceeding has basically documented
22 that. And as a matter of economic theory and
23 regulatory practice and market organization,
24 that is not a surprise.

1 So I think the question before the
2 Commonwealth, its citizens and the legislator
3 and the governor is whether they are content
4 with that result, whether that's the public
5 policy result that we want for the people of
6 the state or whether we need greater state
7 supervision of that reimbursement rate setting
8 process?

9 Dr. Sherenbaum, yesterday, suggested that
10 in his view, state regulation of some sort more
11 than exists today is necessary to produce an
12 economically efficient result, a societally
13 desirable result, and I agree with that.

14 Sorry to go on, but you gave me an
15 open-ended question there.

16 Q. What I -- what I'm going to do at this point is
17 I'm going to ask you a series of questions with
18 regard to the particular reports, but I -- I am
19 going to work with the time we have, and we set
20 aside an hour for this, to get back around to
21 whether it's -- whether you view it as little
22 open-ended questions, but certainly back to the
23 issue of social determinants of health and some
24 of the issues of estate health planning and how

1 that might be in the context of -- of whether
2 regulatory or non-regulatory structures.

3 I would -- I would note before I begin
4 these questions, though, to make a clear
5 distinction, at least in the perspective of my
6 role as assistant Attorney General is that to
7 the extent that we are discussing issues of the
8 particular power, which we call "market
9 leverage" in the market and what we've
10 examined. That's a very different concept than
11 the analysis of market power under an antitrust
12 analysis, which is a legal analysis which would
13 require a different type of review and
14 scrutiny. And I understand it's very easy for
15 the language to -- to be mixed. But I did want
16 to put on the record up front that I am not
17 seeking and not directing questions towards an
18 antitrust analysis but rather towards just kind
19 of what the markets happening. Does that -- do
20 you understand that difference?

21 A. Yes. And I -- although I'm a trained
22 economist, I would not consider myself an
23 antitrust expert, but I would, with some
24 modesty, consider myself an expert in the

1 regulation of utilities and like organizations.

2 Q. Okay. And I think that some of these other
3 factors, you know, that I'll ask about might
4 come back around to some of the -- some of the
5 other considerations we've already talked
6 about.

7 So, to start, the Attorney General
8 examination of healthcare cost trends and
9 drivers, which I'll refer to from here forth as
10 just the AGO report, found that prices paid to
11 both -- by -- by health insurers in the
12 commercial marketplace, the hospitals and
13 physician group -- physician groups, vary
14 significantly within the same geographic areas
15 and amongst providers offering similar services
16 such as academic medical centers that provide
17 tertiary levels of care, and that those
18 differentials were not correlated by -- to a
19 measurable quality to the acuity or sickness of
20 the population being served to the amount of
21 government payer business being served or to
22 the status of the hospital as an academic or
23 research facility. Does that finding, those
24 series of findings, comport with your

1 experience and that of your organization?

2 And I would note, also, one additional
3 thing that we lawyers like too note things
4 probably to often, and I know you have counsel
5 with you, but this examination of you as Paul
6 Levey, to the extent that I will site to the
7 rule of civil procedures, this isn't a 30(b)(6)
8 examination. I'm not seeking to have Beth
9 Israel restricted by your answers. I just
10 wanted to make that clear on the record.

11 A. Thank you. Before I answer, let me just say
12 the basis for my knowledge in answering these
13 questions is being chief executive officer of
14 our hospital. As such, I am kept well informed
15 of our negotiations with the insurance
16 companies and also reasonably well informed of
17 the negotiations of our physician organization
18 with those same insurers.

19 For the most part, I do not participate
20 personally in those negotiations, although I do
21 from time to time. And so there are details of
22 those negotiations that I probably can't
23 answer, but I think I have a generally good
24 sense of what's going on.

1 The answer to your question is yes, the
2 finding does comport with the experience of our
3 organization, and I would say -- I would say so
4 based on a number of conversations that I've
5 had with insurers themselves and with our staff
6 about the manner in which negotiations take
7 place.

8 And those four characteristics that you
9 mentioned, quality of care, sickness of the
10 population served, Medicare, Medicaid and the
11 academic teaching rise to different levels of
12 discussion during those negotiations.

13 Quality of care is perhaps the least
14 discussed item in the negotiations. Sometimes
15 there will be a pay-for-performance component
16 of -- of an insurance contract, but it's
17 actually a very small component, and I cannot
18 recall of a -- a time in which our relative
19 quality of care, as a general matter, for our
20 hospital compared to other like hospitals has
21 ever come up in a positive way, that is to say
22 in affirmative way in -- in the negotiations.
23 And I know that because I've raised that myself
24 with the insurers, saying that given the -- the

1 very strong programs we have in our hospital to
2 reduce harm, to improve quality and safety,
3 shouldn't there be some recognition of that
4 in -- in the rate setting process, the
5 reimbursement rate setting process? And not
6 once, really, has an insurance company
7 responded -- responded in the affirmative to
8 that other than saying, "Well, we'll put in
9 some pay for performance metrics." So both on
10 a nominal level of our own hospital but also a
11 relative level compared to other hospital, it
12 is not an issue.

13 The sickness of the population served or
14 complexity of the service provided, once again,
15 I do not ever recall that that has been a
16 factor in the relative rates that we receive
17 compared to other hospitals or other physicians
18 within the DRG schedule and so on. There
19 are -- there are relative rankings of that, of
20 course, but not when you compare the -- the --
21 not when you try to correlate our reimbursement
22 rates with those of other hospitals and
23 physician groups.

24 The extent to which a provider cares for a

1 large portion of patients on Medicare and
2 Medicaid, there is a component of our
3 negotiation which attempts to recover the
4 shortfall in Medicare and Medicaid payments
5 from the government through the private payer
6 rates. And I think, as we'll talk about later,
7 a component of the rate increases that have
8 existed over the last several years is to
9 makeup for that shortfall, but I've -- I've
10 never heard it phrased in terms our -- of our
11 relative amount of such service compared to
12 other hospitals. It may somehow be built into
13 the rate-making methodology but has never been
14 made explicit to me.

15 And whether a provider is an academic
16 teaching or research facility, clearly, we do
17 have provisions in our rates that recognize the
18 fact that we're a teaching hospital. We do not
19 have a recognition in our rates that we are a
20 research facility, but I think your question is
21 whether the comparative rate of academic
22 teaching in our hospital compared to other
23 academic centers or to non-academic centers,
24 once again, has never been put forth to me as a

1 factor in establishing our rates relative to
2 those of other hospitals.

3 Q. And, again, just drawing on the public
4 testimony, and I -- I don't remember who to
5 really attribute this to and that's probably
6 best in this examination process, while there
7 was some examination through this -- this
8 hearing process of quality, and clearly we
9 looked at -- the Attorney General's office
10 report looked at various quality measures that
11 are out there, there -- the critique from one
12 of the public speakers, there hasn't been
13 enough focus on quality. And so I -- I would
14 ask you what -- what is the kind of right
15 sizing of quality measures, in a way, that
16 could become transparent?

17 A. Well, there's a lot of debate on -- on what
18 would be the appropriate measures of quality
19 that one could use for -- for rate setting
20 purposes. I think Blue Cross Blue Shield and
21 their Alternative Quality Contract has come up
22 with a number of metrics, and I think there are
23 some generally accepted ones, which, of course,
24 are not coming to mind right now. I'm happy to

1 provide later. But the point is, thus far,
2 whatever you think they might be, have not been
3 prime determinants of the relative level of
4 rates paid among facilities or physician
5 groups. It's just not a big factor at all.

6 Q. And, again, I understand that you don't have
7 current recollection of the quality measures
8 and the DQC contracts of Blue Cross. Do you
9 have a current opinion as to whether some --
10 directionally, some of those measures are the
11 right measures?

12 A. Well, I think they're -- they're grossly
13 appropriate but maybe don't tell the whole
14 story. For -- for our hospital, we've adopted
15 a strategic plan and have a board vote that is
16 directed to eliminating preventable harm in the
17 hospital. That would be harm that comes from
18 hospital acquired infections. That would come
19 from falls, other metrics like that. In fact,
20 you can go to our website, BIDMC.org, and see
21 those listed.

22 We believe as a -- as a primary measure of
23 quality, reduction of harm is -- is tops
24 because after all, hospitals are supposed to be

1 in the business of making people better rather
2 than harming them. And we believe that if a
3 hospital focuses on reduction of harm, that
4 other quality metrics follow.

5 There are others that are -- that are used
6 regularly. For example, in particular service
7 areas, there's something called "door to
8 balloon time" in cardiac care. If someone
9 comes in with chest pain, there's an
10 expectation and a hope that that person would
11 be seen in a cath lab within 90 minutes. And
12 one of the metrics that exist is what
13 percentage of the time do your patients who
14 show up with chest pains have their
15 catheterization within the 90 minutes? Many of
16 us shoot to -- to reach 100 percent on that.
17 In fact, our hospital has been at 100 percent
18 on that metric for -- for quite some time.

19 Likewise, there -- there are other metrics,
20 elimination of central line infections,
21 elimination of ventilator associated pneumonia
22 and the like. So they're both -- they're
23 gross -- gross measures, but they're also
24 service specific measures that can be used.

1 I think the thing to recognize at this
2 point is that every hospital I know keeps track
3 of these things, virtually, in real-time,
4 month-by-month, week-by-week, day-by-day. So
5 this is not a matter of asking hospitals to
6 collect new data on new metrics. These are
7 generally excepted metrics. We have the world
8 of expert organization on healthcare quality in
9 Massachusetts at the Institute for Healthcare
10 Improvement in Cambridge. They have a list of
11 things by which they think hospitals should be
12 judged. I don't think we have to go very far
13 to figure out what to do here.

14 Q. And as far as the transparency that the website
15 that you have provides that information, do
16 other hospitals provide that same type of
17 transparency of their measures?

18 A. To a greater or lesser extent. I notice that
19 Mass. General, for example, publishes its door
20 to balloon time. I noticed they were at
21 something like 73 percent compliance with the
22 90-minute standard. Mount Auburn Hospital does
23 an excellent job publishing its medication
24 error rates. New England Baptist also does

1 that. So it's to a greater or lesser extent.
2 I'd say for the most part, lesser extent. But
3 that's -- that's a matter of choice.

4 Once again, all -- I believe all the
5 hospitals collect these data, whether they
6 choose to publish them or not, thus far, has
7 been voluntary.

8 Q. If -- if we're trying to get a more value based
9 system for the economy, whether through
10 regulation or transparency, would the required
11 standardization of some of those measures, if
12 they're not already by these well-respected
13 entities, and the public reporting of those
14 measures be a step in the right direction?

15 A. Well, that would be an essential thing. You'd
16 have to pick which metrics you want to use and
17 you'd have to be open in public about the
18 hospital and the physicians' group success in
19 meeting those metrics.

20 Q. Would the -- obviously, we're trying to put it
21 in the context of value. Would the price or
22 some form of price relativity also be an
23 essential element as far as the transparency?

24 A. I don't know. You mean -- I'm sorry. I was

1 misinterpreting your question. I thought you
2 were asking whether -- whether quality is an
3 essential component of pricing, and -- and I
4 was going to say in response to that, that
5 sometimes mere transparency of quality metrics
6 acts to improve quality. Although to the
7 extent you can tie it to pricing, that gives it
8 an additional incentive.

9 On the -- on the direct question of -- of
10 pricing transparency, we currently operate
11 under a system in which pricing is hidden from
12 everybody. And if -- if you adopt my more
13 public utility view of these essential services
14 for the population of Massachusetts, it's hard
15 for me to understand why the pricing between a
16 given insurance company and a given provider,
17 provider group, doctors, should be -- should
18 not be open and public at this point.

19 I know we'll talk in a minute about other
20 state actions that could take place to improve
21 this overall marketplace. The -- the mere
22 existence of sunshine on the rates that are
23 charged and collected between insurance
24 companies and providers, I think, would create

1 a -- what amounts to a moral force that would
2 help alleviate some of the market power issues
3 that we're seeing demonstrated in your chart
4 prepared by the Attorney General's office.

5 Because then, frankly, if you were in a
6 negotiation, you could at least ask the
7 question, why is my rate different than
8 somebody else? And it's really hard in that
9 environment to just say, well, the difference
10 is totally because we think they have more
11 market power, although that could still exist
12 as -- as a component.

13 So I think transparency is -- would be
14 valuable. I don't see -- to -- to turn the
15 question around the other way, I don't see a
16 downside from transparency of pricing. I don't
17 see how society loses.

18 Now, I understand Mr. Dreyfus, yesterday,
19 said he was concerned that open pricing would
20 lead to a race for the summit, that everybody
21 would move up. Well, I think what it would
22 move towards is to the median rather than to
23 the top or the bottom. Because I think
24 transparency of pricing works, to a certain

1 extent, to the advantage of lower paid
2 providers, but it also works to the advantage
3 of higher paying insurance companies at the two
4 ends of the spectrum. So I think it would be a
5 regression towards the mean rather than towards
6 the extreme.

7 Q. As far as pricing, it might be -- so instead of
8 it being inflationary to the market, there
9 might be some convergence around a mean as far
10 as pricing?

11 A. I believe that would be the case, but that's a
12 judgment call, obviously. But I -- I think
13 generally in markets -- you know, if you go
14 back to the economist definition of a market
15 where you have knowledgeable buyers and sellers
16 about the quality and price of what's being
17 offered, markets tend to move towards an
18 efficient price, not a monopoly inspired price
19 but an efficient price.

20 Q. In the absence of market controls, I think the
21 two concerns that I had heard raised this week
22 or that I believe were raised this week was one
23 that might have an upward pressure on those who
24 are at the lower end of rates; the other, which

1 you've addressed, the other was that if there
2 isn't consumer incentives, it might actually
3 drive volume towards more expensive centers.
4 Because without information, if it's more
5 expensive, the perception is it must be better.

6 A. Well, we -- we talked about that at our panel
7 the other day, about the difficulty of
8 insurance companies. I think Mr. Roosevelt was
9 talking about this, offering a limited network
10 product at a lower price because the public
11 perception, as you suggest, is that the higher
12 priced product offers more quality and more
13 value in that respect. That's why accompanying
14 price transparency, you need to have the
15 quality transparency, because what that will
16 indicate is more accurate -- a more accurate
17 reflection of actual qualities of differentials
18 among providers.

19 Right now, certain providers have a
20 reputational advantage based on history, custom
21 and the like, that may or may not be warranted
22 based on what they're actually doing with
23 patients. I would suggest to you, based on
24 what I know about underlying characteristics of

1 patient care in Massachusetts and Boston
2 Metropolitan area, that the reputational
3 advantage that is currently enjoyed by a number
4 of providers appears to have no real basis in
5 fact. And that's -- that's both with --
6 among -- within and among the academic centers
7 relative to one another, but also between the
8 community hospitals and the academic centers.

9 Many people who live in the outlying
10 communities feel they need to come to Boston to
11 have certain procedures done when they can be
12 done just as well in their hometown. And the
13 problem with that, of course, is they then move
14 from a lower cost facility to a higher cost
15 facility, helping to raise the cost of health
16 care for all.

17 So healthcare price transparency and
18 quality transparency would have the advantage
19 of eliminating reputational advantages that
20 currently have no basis in fact or might
21 currently have no basis in fact.

22 Q. I'm going to -- I'm going to move on to -- from
23 price to cost, and the Attorney General's
24 report and also some of the comments by

1 panelists this week have talked about how price
2 variations, what's being compensated by health
3 plans, isn't adequately explained by internal
4 costs of the hospitals. And, actually, a panel
5 the other day, I think it was Nancy Kane and
6 some of the MedPAC Association talked about
7 costing to price. Can you react? Is that
8 consistent with what you've seen in the market?

9 A. Well, to the first part of that, the pricing is
10 definitely not based on costs. That's proven
11 in the data that you've presented in your
12 report. It's also proven by the nature of the
13 negotiations that go on between us and
14 insurance companies. Very seldom are there any
15 real questions about our underlying costs and
16 our need for capital and the like.

17 The fact that some percentage of
18 Massachusetts hospitals, I see Lynn Nichols
19 here, maybe she can tell us the percentage,
20 currently has a margin less than zero or an
21 operating margin that is not sufficient to
22 replace plant and equipment. That is to say it
23 might cover depreciation but doesn't cover
24 replacement costs as a prima-facie

1 demonstration that insurance company rates
2 don't cover costs of many hospitals in the
3 state. And -- and if rates were based on
4 costs, the hospitals in the state, generally,
5 would be able to earn a margin sufficient to
6 cover their reasonable operating costs and to
7 return -- and a return of capital and -- for
8 the future investment. That's the definition
9 of a reasonable price in the marketplace. So
10 that is the first part of your question.

11 The second part is whether people, in
12 essence, in a hospital spend up to the level of
13 the rates that they receive. And the answer to
14 that is so that if someone is getting -- if
15 some institution is getting higher than average
16 rates, are they more likely to have higher than
17 average costs? And as I think we discussed the
18 other day during my testimony, if -- if that
19 were not the case, hospitals with sufficiently
20 higher rates would be earning super normal
21 returns. That is to say their margins would be
22 well above average.

23 It doesn't appear that that is happening,
24 that they're well above average. So that

1 suggests that they're actually spending the
2 money they receive, both for operating costs
3 and for reinvestment, expansion of facilities,
4 building ambulatory care centers in Foxborough
5 or Danvers or wherever it might be, because
6 those funds are available to them.

7 Q. As far as that spending to cost, and you
8 mentioned some -- some particular ambulatory
9 centers. As far as various, and I know you
10 have a wonderful chief financial officer and so
11 they sent and I should pose these questions to
12 him at some other time, but what other
13 financial indicators that you look for in
14 financial reports beyond operating margin,
15 which would show the relative financial health,
16 whether it's -- you know, some that I've heard
17 are, you know, day's cash, capital ratio --

18 A. Right. Their ratios of debt to so-called
19 equity, if equity is the right word for
20 non-profits, day's cash on hand is important.
21 The actual margin is important. The -- the
22 annual capital spending relative to
23 depreciation is important. I think the
24 standard metrics that a bond rating agency

1 would use give you a pretty good idea of the
2 relative financial health of an organization.

3 With regard to -- perhaps a relative degree
4 to which hospitals with higher reimbursement
5 rates incur more expenses, you might look at
6 the degree to which they find they need to
7 subsidize government payers using private payer
8 funds. Why is that a metric?

9 Well, if someone -- so the government
10 payers, as we know, pay virtually the same
11 amount to every hospital for similar services
12 with minor differences and so on. So if two
13 hospitals that are offering comparable levels
14 of government service, Medicare and Medicaid
15 service, and if one of them gets paid more by
16 private payers than the others -- the other,
17 and that hospital system has a relatively
18 bigger deficit in recovering its cost from its
19 Medicare and Medicaid rates, that would
20 indicate that its overall cost structure is
21 higher than the other hospital. And one of the
22 explanations for that would likely be that
23 they've incurred a higher cost structure
24 because they know that the funds are available

1 to pay for that higher cost structure, if that
2 was a clear explanation?

3 Q. Well, in -- in this particular proceeding, Beth
4 Israel has filed margins for its commercial and
5 margins for its government and margins for its
6 other business.

7 A. Right.

8 Q. And some of the other medical centers have also
9 filed similar information. So the extent
10 that -- and, again, I'll just stay in
11 hypothetical, that, you know, institution A had
12 a -- a negative margin of 10 percent on the
13 government business and hospital B had a
14 negative 30 percent margin, that difference
15 because of if they're both academic medical
16 centers, would roughly equate to a cost
17 structure difference?

18 A. I think it -- I'm not sure if it totally
19 equates to that because there are probably
20 other concerns. But I -- I believe it would be
21 reasonable to assume that some component of the
22 difference is related to the underlying cost
23 structure of -- of the two hospitals.

24 Q. Beyond these types of metrics, how do we --

1 what ways could we advance the transparency of
2 cost in the system? Right now, there are
3 reports that are filed with the division for --
4 three reports, that some have suggested are
5 limited utility. Can you give some sense as to
6 whether you agree that they are limited
7 utility, what can be done to improve the cost
8 to the Commonwealth?

9 A. I'm not that familiar with the details of that,
10 but I would just say that we had this issue
11 with regard to public utilities and telephone
12 companies and the like and even with the same
13 set of accounts, there are -- there are
14 different decisions made about how to allocate
15 costs among those county wide. So I'm not sure
16 what could be done to improve the current
17 financial reporting other than to know in -- in
18 pretty good detail what's in each line item so
19 that you really understand what's there.

20 I know that we as a hospital try to look at
21 benchmarks of -- of cost factors. I think many
22 of us do this in terms of full-time employees
23 per adjusted occupied bed and the like,
24 pharmaceutical expenses per patient and -- and

1 all those kinds of things, and there are
2 benchmarks in metrics out there that we all
3 look at, and then the next moment we say, "But
4 they don't all apply as well." So there's a
5 lot of judgment that goes into those kinds of
6 things.

7 But in a way, you don't -- you and -- the
8 state government shouldn't find itself beholden
9 to a particular cost accounting system in order
10 to solve some of the problems we've talked
11 about with regard to market power. The mere
12 transparency of the rates themselves, the
13 reimbursement rates themselves will be helpful,
14 and I have other ideas we can talk about as
15 well, and you need to understand the cost
16 accounting, but it may not -- may not tell you
17 the whole story.

18 Q. Moving on, another finding from the Attorney
19 General's report was that a variation in total
20 medical expenses on a per member, per month
21 basis wasn't correlated to the historical
22 information as far as whether some entity was
23 fee for service versus globally paid or adhered
24 some risk in the contract. Was that finding

1 surprising to you?

2 A. The degree to which there was a lack of
3 correlation was surprising to me, because I've
4 been hearing from a lot of people here in
5 Massachusetts and around the country that
6 the -- the answer to controlling healthcare
7 expenditures would be to move to a -- more of a
8 risk basis, a capitated or global system as it
9 is now called. And I think your -- your data
10 shows that that is not necessarily the case,
11 and -- and your data was from 2008, as I
12 recall; correct? So that it doesn't -- it
13 doesn't yet include the new Alternative Quality
14 Contract signed by Blue Cross Blue Shield for
15 capitated rates. And my understanding is that
16 in an effort to sign those contracts early on
17 with certain provider groups and physician
18 groups -- hospitals and physician groups, Blue
19 Cross Blue Shield actually made it quite
20 attractive financially to a number of those
21 groups to sign on with not only attractive,
22 initial payment levels but supplemental
23 payments for infrastructure and the like that
24 may not even show up in the rates per se.

1 And so I think if you were to -- it would
2 be an interesting exercise to actually look at
3 the 2009 numbers, too, that would -- and then
4 include those new risk contracts to see if what
5 you found in 2008, remains the same.

6 Perhaps over time -- I think the theory
7 over time with the Alternative Quality Contract
8 is that it would slow the growth rate, and
9 that -- that may be the case. I don't want to
10 say that it isn't, but I'm just saying for the
11 data we have so far, I think you've
12 demonstrated -- your office has demonstrated
13 that that's not the case that it necessarily
14 results in lower healthcare costs.

15 Q. Earlier, we talked about spending to price.
16 Could this also be, to some extent, a result of
17 spending to price, and, again, a total medical
18 expenditure model as opposed to a reimbursement
19 structure model?

20 A. I'm not sure, to tell you the truth, not that
21 what I was saying before wasn't all the truth,
22 also.

23 Q. The -- the division's reports and our reports,
24 while focus on a particular timeframe, the

1 last, two -- you know, three, four, five years,
2 looked at the significance of -- of increases
3 in price as well as the increases in
4 utilization as important drivers of -- of -- of
5 our current medical trend. Is that -- the
6 significance of price in that equation
7 something that surprises you based upon the
8 experience of your organization?

9 A. I was a bit surprised by your conclusion and it
10 wasn't until I talked to Mr. Fisher, our CFO,
11 and we -- we went over it, that I understood
12 how -- how you came to that conclusion. I
13 think it's correct as it's stated.

14 I was surprised because when -- I know when
15 we've put our budgets together and we've looked
16 at increases in revenues for our hospital
17 year-to-year, the growth in those revenues
18 tended to be split more 50/50 between new --
19 new rates and utilization or demand. Whereas
20 your numbers, I believe, showed rates being
21 75 percent and -- and utilization being more
22 like 25 percent between, if I recall correctly.

23 But then Steve pointed out to me that the
24 way you were looking at it also included -- in

1 essence, included the shortfall in payments by
2 the federal and state government through
3 Medicare and Medicaid that then get rolled into
4 the commercial insurance rates. So from the
5 point of view of your organization looking at
6 commercial insurance rates, if you then add in
7 the shortfall for Medicare and Medicaid, it
8 would look more likely that -- that price is a
9 bigger component than -- than -- than
10 utilization. But if you look at it from our
11 point of view, on the ground, we were seeing it
12 about 50/50. So I think -- I think the two
13 numbers are compatible because of the different
14 lens through which they've been viewed.

15 Q. And I just would note that the information that
16 we provided, the Attorney General's report, was
17 the -- the purpose was to hold up a mirror and
18 report back what we heard from payers and
19 providers as opposed to suggesting that one
20 approach was superior.

21 A. No. That's what I'm saying. They're
22 consistent. It's just my initial reaction when
23 I saw them was, hmm, this doesn't seem
24 consistent with the way we do budgeting. But

1 then as Steve explained it to me, he said,
2 "Well, it's perfectly consistent with what was
3 said."

4 Q. But if -- if I -- if knowing where the -- what
5 the components of trend are, obviously,
6 important to the discussion of how to control
7 trend, is there a way to improve, on a going
8 forth basis, these will be annual hearings with
9 continual scrutiny, that the issue is Blue
10 Cross, in its mission to us and is included in
11 the report, broke it up into price, unit price,
12 a mixture of factors that they term "severity"
13 and then utilization. How do we -- what is a
14 way of reconciling where we're at that would be
15 consistent with how Beth Israel uses --

16 A. I'm not suggesting it's inconsistent. I think
17 the way you're presenting it is fine. The
18 underlying question is perhaps the more
19 interesting one to the extent that this --
20 these increases in costs are the result of -- I
21 mean, is to look at the under -- of the
22 components of cost increases to the extent, for
23 example, that utilization of specialty services
24 is growing, either as a result of demographic

1 trends or whatever it is. The underlying
2 policy question is what can be done about that?

3 There were a number of suggestions during
4 this hearing that to the extent we could make
5 it more attractive for primary care doctors,
6 more feasible for primary care doctors to spend
7 more time with patients, patients whose
8 families they know and whose histories they
9 know, and move primary care doctors out of
10 their current what is often a triage function
11 rather than a real patient care function. To
12 the extent we could do that, it would help
13 ameliorate the use of higher-end specialty
14 care. As a societal goal, that is extremely
15 desirable.

16 If you look at Europe and -- and other
17 places, one of reasons they're able to control
18 their healthcare cost is because they have very
19 strong primary care systems and they make
20 relatively less use of secondary and tertiary
21 care.

22 So a question for the Commonwealth is how
23 could we make that happen? Well, I would
24 suggest to the Commonwealth that the

1 Commonwealth itself, as a purchaser, could make
2 that happen.

3 Mrs. Mitchell was here from the Group
4 Insurance Commission. They have a good deal of
5 bargaining power with -- with regard to the
6 insurance companies who provide that service.
7 They -- they could say as a matter of policy we
8 would like you to pay primary care doctors more
9 for their visit so they don't just spend the
10 nominal 18 minutes with a patient. Likewise,
11 the state Medicaid program could do that.
12 Likewise, to the extent the Connector Authority
13 has this authority, it could require insurance
14 companies offering the subsidized health
15 insurance plans in Massachusetts to, likewise,
16 pay primary care doctors more with the
17 long-term benefit of reducing the higher-end
18 secondary and tertiary care.

19 So we can -- we could actually do the
20 laboratory tests of this theory right here in
21 Massachusetts. Now, in the short run, it might
22 increase costs because you'd have both the
23 primary care network and the -- and the
24 specialists in place, but over time, the theory

1 goes, it would decrease cost. And if we're
2 talking about bending the cost care over time,
3 that, from everything I've heard from all the
4 experts in the world that I've talked to, seems
5 to be the primary way to get it built up.

6 Q. To follow up on -- on that answer, I think
7 there's been a fair amount of discussion during
8 this -- these hearings about a very hospital
9 centric systems.

10 A. Yes.

11 Q. And, you know, we're -- you know, one of your
12 earlier question -- answers talked about
13 physicians, often specialty groups, aligning
14 with hospitals, driving volume in certain
15 directions. And whether it's, again,
16 Ms. Lynch's comments or -- or Nancy Turnbull's
17 comments about social determinants and kind
18 of -- you know, kind of flipping the parodyne
19 to some extent, how do we, either by -- you
20 know, either with the -- whether the AQC can
21 start to do that, whether payment reform can
22 start to do that, start to get the -- the lens
23 to be the right lens as far as starting from
24 the patients' perspective with primary care?

1 A. I think we have to recognize with regard to the
2 recommendations of the Payment Reform
3 Commission and a suggestion that we move to
4 global payments, that there are a lot of
5 complexities with the movement toward global
6 payments that the commission report did not
7 address, that it explicitly decided to leave to
8 the next group.

9 One of them, which is -- was discussed
10 sometime during this hearing, was the idea that
11 a move to global payment actually shifts
12 actuarial risk from insurance companies to
13 providers. I mean, that's the -- we call them
14 "risk contracts" for a reason.

15 Now, to the extent that that's the case and
16 to the extent that insurance companies can
17 thereby shed risk, there should be a
18 countervailing reduction in the capital
19 requirements of those insurance companies and
20 the savings from those capital requirements
21 should then be passed along to the subscribers
22 of those insurance companies. Thus far, no one
23 has really talked about that savings and how it
24 would be passed along. I'm just mentioning

1 that as one example of the problems of moving
2 towards a -- the recommendations of the Payment
3 Reform Commission.

4 But to your underlying question, there are
5 societal determinants of health that have to do
6 with the way health care is delivered, but
7 there's a bigger component, perhaps, that has
8 to do with the way people live and the degree
9 to which our society chooses to intervene in
10 the way people live.

11 As a general matter, my belief is that our
12 society does not like to intervene in the way
13 people live by telling us what to eat, whether
14 to smoke or not, whether to do things that we
15 know could make people healthier. So the
16 question is when you're dealing with the
17 healthcare system, per se, as opposed to the
18 public health system, when you're dealing with
19 primary care doctors, secondary care, tertiary
20 care, skilled-nursing facilities and the like,
21 what recommendations or what policies with
22 regard to the structure of reimbursement in
23 that system make it more likely that the social
24 determinants of health that are germane to that

1 part of the system will be carried out?

2 One theory is that a global payment system
3 would cause that to occur. Another theory is
4 the one I stated before, which is -- which, by
5 the way, may not be mutually inconsistent, to
6 the extent we actually gave people primary care
7 that properly served the primary care function,
8 we might achieve a lot of those results, also,
9 even under a fee-for-service system.

10 That's untested. Both are untested. My
11 belief in public policy changes is that they
12 should be done incrementally and carefully.
13 There is nothing, even while we're considering
14 where to go on global payments, there is
15 nothing to prohibit, right now, the insurers
16 and the state and Medicaid and the GIC and so
17 on, from adopting an approach to reimbursement
18 of primary care that would be consistent with
19 the goals of payment -- the Payment Reform
20 Commission but that don't require a
21 reallocation of risk from insurance companies
22 to provide. And so while we're waiting to
23 figure out all the rest, why not move forward
24 on that, as I said before, and do some

1 experiments and see if we can get some results?

2 Q. Would -- while -- while an important component
3 of primary care is compensated, are there --
4 and whether that be primary care physician or
5 RNs practicing as primary care --

6 A. Right.

7 Q. -- providers, how do we, in a sense, kind of
8 the growth of that market?

9 Is it our academic medical centers? Are
10 they producing physicians who -- or RNs that
11 are focused on that work or is it just
12 compensation, compensation, compensation?

13 A. Well, I -- I think people vote with their feet
14 and if you look at the graduating classes of
15 the medical schools, doctors are choosing not
16 to become primary care doctors because they
17 know that it -- it won't compensate them as
18 well as -- as -- as other -- other specialties.

19 So if there were a long-term commitment and
20 dedicated commitment on the compensation side,
21 I think that would start to make a difference.
22 Whether it would make a total difference or
23 not, I don't know, but it's -- you can't force
24 people to take on certain careers if they know

1 they can make more money being a dermatologist.

2 Q. As far as I -- because one of the findings of
3 the Division of Healthcare Science and Policy
4 was that -- that the -- we have a health system
5 dominated by a higher number of specialty
6 doctors just to --

7 A. Right.

8 Q. -- this point and by academic medical settings,
9 both of which tend to be costlier -- provide
10 costlier care.

11 I mean, is there -- should -- should either
12 health plans or the system set limits on the
13 relative ratio of primary care to specialists?

14 A. No. I think those will be derivative of the --
15 of the reimbursement system that's in place,
16 whether the theory of the global payment system
17 or the theory that I've just set forth about
18 this compensating primary care doctors
19 appropriately, is that so doing will result in
20 less use of specialty care and that over time,
21 the number of specialists as a percentage of
22 the number of physicians in the state will
23 drop, and -- and that will be the economically
24 efficient, societal, desirable result, if we do

1 it right.

2 Q. And staying on -- on payment reform, one of the
3 findings of the division' report -- reports was
4 that the way healthcare providers are paid
5 rely -- rewards those that provide a high
6 number of individual services rather than those
7 that are best at coordinating care and
8 delivering good quality services in less
9 expensive settings.

10 A. That's true, and -- and so the interesting
11 issue here, we talked about this briefly at the
12 hearing yesterday, there are many businesses,
13 services and production kind of businesses out
14 in the world that are totally compensated on a
15 fee-for-service basis. Most other kinds of
16 industries, if you think about it, are paid
17 that way. We don't worry in those businesses
18 about whether there's an economically efficient
19 level of production of automobiles or toys or
20 loaves of bread, all of which are purchased on
21 a fee-for-service basis.

22 Why don't we worry about that? We don't
23 worry about that because those markets behave
24 like real market, for the most part. They're

1 not monopoly dominated. There's transparency
2 of quality and price. I can go on the Internet
3 and if I'm interested in buying a car, I can
4 learn more about buying that car, its history,
5 its reliability record, its price, its resale
6 value, than anything to do with any purchase I
7 make, any choice I make in the healthcare
8 department. So, to the extent that we can move
9 this system to more of a real marketplace, that
10 will help in that regard.

11 Now, it probably is not the total answer,
12 because it's the nature of healthcare that a
13 certain portion of the costs are always hidden.
14 We buy insurance. We don't necessarily buy the
15 services we need when we're sick, and so there
16 is not a direct correlation between my decision
17 as a consumer to purchase a given service from
18 the healthcare system and its price. There's
19 always some intermediary in the way that --
20 that makes that not quite a perfect
21 transaction. But we are so far from even close
22 to perfection here in Massachusetts with regard
23 to the reimbursement system, that there would
24 certainly be some gain to our society in

1 remedying some of the inequalities and
2 disparities that the Attorney General has
3 noticed -- noted in the report. So I would
4 just say let's take it step-by-step.

5 You know, I -- I once said to our friends
6 at Blue Cross when they were talking to me
7 about the Alternative Quality Contract, you
8 know, when you're an insurance company and the
9 thing you have to -- to use to influence
10 behavior is -- is the reimbursement system,
11 it's like the old adage, when you have a
12 hammer, everything looks like a nail. Of
13 course, that's what they're focusing on, but
14 there are other aspects of this system that can
15 be equally important and that can be improved
16 that may not require major changes in the
17 day-to-day reimbursement scheme. I would -- I
18 would precede incrementally and cautiously on
19 it.

20 As I think Dr. Gottlieb said earlier today,
21 there's a -- there is a danger in a global
22 payment also of under serving the population
23 relative to its medical needs. That was the --
24 the case the first time managed care capitated

1 contracts exist. Presumably, we'd be better at
2 it now, but we'd probably make other mistakes
3 now. So as I say, I think as a matter of
4 making public policy, it's better to do things
5 incrementally. Evaluate, experiment and see
6 how it goes before taking the next step.

7 Q. Speaking about experiments and the next step,
8 Mr. Dreyfus did talk about the -- the number of
9 entities or the percentage of the population
10 that now under the AQC contract. Has Beth
11 Israel entered in any AQC contract?

12 A. We've been in negotiations with Blue Cross Blue
13 Shield for probably about two years now with
14 regard to the AQC, and we -- we found them to
15 be very difficult negotiations and perhaps the
16 people at Blue Cross feel the same way, and we
17 found them to be difficult negotiations without
18 talking about particular numbers here because I
19 don't think that's our intent here, the -- the
20 hoped for trend in overall medical costs
21 that -- that Blue Cross was aiming for us to
22 achieve to make the AQC profitable, I use the
23 term "profitable," in other words, positive
24 margin for our organization, was -- has been,

1 in our view, extreme relative to what they have
2 been able to demonstrate to us is possible with
3 regard to likely efficiency improvements in the
4 delivery of care. In other words, we've said
5 to them, "Show us, based on our current
6 delivery of care to our patients, where we are
7 out of line relative to statewide averages or
8 even to best practices." And when we've
9 compiled those results that they've given us
10 and compared them to the pricing formula that
11 they've proposed, it just hasn't added up. And
12 so we have felt and, in particular, our
13 physicians' organization has felt that it would
14 be fiscally irresponsible to sign the contracts
15 that have been offered to us so far.

16 We do not have a philosophical objection
17 to -- to entering into risk contracts and so I
18 want to make that clear, but -- but we have a
19 financial responsibility to our organizations,
20 whether it's our physician organization or our
21 hospital. We do not have cash reserves of the
22 type that an insurance company has, and when I
23 talked before about shifting actuarial risk,
24 that is a component of the AQC.

1 We've proposed an alternative approach to
2 the AQC, which would be based on a cost sharing
3 kind of approach of the kind recommended by
4 Elliot Fisher at Dartmouth, where an annual
5 budget would be set and to the extent we'd beat
6 that budget, we would share the gains of
7 beating that budget with the insurance company.
8 The response from -- from Blue Cross Blue
9 Shield has been to turn that down flat. We
10 suggested it as an -- as an intermediate step
11 along the path to an AQC.

12 We also, I should mention, in our
13 discussions with -- with Blue Cross Blue Shield
14 with regard to the AQC, now that we are further
15 along in time than some of the earlier people
16 who signed that contract, it's become very
17 clear as I've talked to my colleagues around
18 the state that those people who signed the
19 contracts earlier were offered a more generous
20 package than those who are coming along now,
21 and I can't blame them for signing those
22 contracts early on. Perhaps we should have
23 done the same thing, looking back on it. But I
24 think it's a fact of life that the -- perhaps

1 it's a result of the financial condition that
2 Blue Cross now finds itself in, but those
3 contracts, the one being offered to us are
4 clearly not as generous as those that have been
5 offered to other institutions and physicians
6 and groups previously.

7 Q. I have a few more questions --

8 A. Okay.

9 Q. -- and I know that the hour is -- and those
10 bells weren't for us, I don't believe.

11 A. Okay. Ellen is patiently waiting there.

12 Q. But I -- we -- I want to ask you about some
13 other findings of the division because I think
14 they had a lot of the very important findings.

15 One of the ones, which is, I think, you
16 know, kind of the -- kind of the capstone to
17 everything is where medical trend is, and they
18 found that between 2006 and 2008, private
19 spending per insured individual health care in
20 Massachusetts grew by 15.5 percent, more than 7
21 percent. Is that consistent with what your
22 work shows you?

23 A. I don't know how to answer that. I know
24 that -- I know that our budget has not

1 increased by that much, but we're not the
2 total -- the sum of all healthcare expenditures
3 in this -- in the state. And I have no reason
4 to question their number, but I can't say it
5 comports with the experience of
6 our organization.

7 Q. What -- what would be the -- I mean, obviously,
8 it's -- because it's statewide, it's built up
9 of a lot of pieces that aren't -- aren't even
10 hospitals.

11 A. Right. Nursing homes --

12 Q. It's nursing care facilities --

13 A. -- all kinds of things.

14 Q. -- and a lot of everything, a very
15 comprehensive review that they performed.

16 How does medical trend for your
17 organization compare to medical trend for the
18 statewide average?

19 A. I don't remember. I think we provided that
20 information to you, but I'm sorry I don't
21 remember it. We can get it for you.

22 Q. So it might be in the pre-file testimony
23 responses?

24 A. If it isn't, we're happy to get it to you.

1 Q. Do you think directionally, it's lower than
2 that?

3 A. Oh, I -- I think so.

4 Q. All right.

5 A. It has to be because as I say, our -- our
6 budget has not increased by -- by that amount
7 per year and so it has to be different from
8 that.

9 Q. Another important finding of the -- of the
10 division's work was with regards to the trends
11 of premiums, and I understand that your
12 business is not insurance premiums --

13 A. Right.

14 Q. -- but rather running a hospital.

15 But their report found that from 2007 to
16 2008, adjusted small group premiums grew by
17 5.8 percent, midsize group premiums grew by
18 4.8 percent, and large group rates grew by
19 actually higher than midsize groups at 5.4.
20 That being so, the smaller the highest rate,
21 large group, middle rate, and midsize group
22 the -- the lowest rate. How does the
23 experience of your organization comport with
24 this?

1 And I'm going to -- I'm going to break one
2 of the rules by asking two questions, which is,
3 does your organization set rates or do anything
4 differently depending upon whether it's a small
5 group, midsize group or large group?

6 A. We negotiate an overall contract with the
7 insurers, and then they determine their
8 products that they sell to market, and we do
9 not have an influence over how they price those
10 products. So I can't answer your question in
11 terms of how it comports with the experience of
12 our organization.

13 We could get you, if it would be helpful,
14 the experience of our organization as a
15 self-insured organization with regard to our
16 own employee increase in medical expenditures
17 and, therefore, the -- what amounts to the
18 implicit cost of insurance for ourselves,
19 and -- and you could see how it compares to
20 today's standards.

21 Q. And -- and just to make sure I understand the
22 answer, that it's -- to the extent that there
23 are rate differentials in the premium rates, it
24 isn't flowing from any kind of negotiations.

1 Its negotiation, while it sets the -- the
2 overall costs of services at your facility, it
3 isn't differentiated by group size.

4 A. That's correct.

5 Q. Okay. We are coming to a conclosed --
6 conclusion with this, so I want to draw your
7 attention back to some of the opening comments
8 that you made with regard to answers with
9 regard to the kind of -- the kind of condition
10 of -- of the system and, you know, some of the
11 comparisons to regulated utilities, but with a
12 specific focus on reaction to some of the
13 comments that were made this week on -- on how
14 to improve our system as we move towards
15 payment reform. How -- how -- how -- how --
16 what you would caution or recommend the
17 Commonwealth or consider?

18 A. I would -- I would ask you to consider the
19 following ideas, just a few, and let me just
20 rattle them off.

21 First, I have now heard over and over and
22 over again that 90 percent of the money
23 collected by insurance companies is paid out
24 for medical expenses and that, quote, only

1 10 percent is used for administrative costs.
2 It appears to me that that 10 percent has
3 remained constant over the years,
4 notwithstanding a dramatic increase in overall
5 medical costs. So that the 10 percent is not a
6 constant. It's a growing number of dollars
7 each year.

8 My experience dealing with other financial
9 services industries, including insurance
10 companies, is that they have over time been
11 able to reduce their administrative costs as a
12 percentage of total revenues because of
13 improvements in data processing and in other --
14 the other transactional aspects of financial
15 services industries. I would like to see the
16 Commonwealth, through its Division of
17 Insurance, investigate the question of why the
18 10 percent administrative cost component of the
19 insurance companies seems to remain constant.

20 I've talked -- the second item, I've talked
21 before about the power of the Commonwealth as a
22 purchaser in influencing the direction of
23 healthcare costs and the value that might inure
24 to the population if the GIC, if Medicaid, if

1 the Connector Authority were to evaluate
2 experiments in which primary care doctors were
3 paid better so that they could be more than
4 triage doctors aligned with continued care and
5 help reduce the use of specialists. I would
6 suggest that.

7 The kind of transparency that you've
8 presented in this hearing is very valuable.
9 Frankly, it's a watershed. I think that should
10 be continued, but I think it should be expanded
11 to provide to the public, the legislator and
12 regulators, transparency around particular
13 commonly used medical procedures and to focus
14 on the price charged to insurance companies,
15 for example, by physicians in different
16 networks for commonly used clinical procedures.

17 For example, what does a doctor get paid --
18 a GI doctor get paid for doing a colonoscopy, a
19 regular colonoscopy, depending on whether that
20 doctor is part of one network versus another
21 network versus another network? The idea of
22 doing that kind of thing would be to take these
23 broad numbers and make them more tangible for
24 the public and regulators and legislators to

1 understand. Because the -- very often, you get
2 the argument that one system or the other
3 deserves higher rates because of whatever,
4 higher quality, academic mission or whatever.
5 Well, frankly, a colonoscopy is a colonoscopy
6 is a colonoscopy, and I think it would be very
7 powerful for the public to see that three
8 community doctors providing service within two
9 miles of one another in a given community in
10 the western suburbs get a 30 or 40 percent
11 difference in what they get paid for that. I
12 think people -- I think that would end -- lend
13 more moral authority to the moral authority
14 you've already brought to the table.

15 I think I'd like to suggest that the
16 Attorney General consider providing
17 representation during the negotiating sessions
18 between providers and insurance companies, to
19 be in the room to watch what happens, to feel
20 free to ask questions, not to take sides but
21 just to watch what happens because the private
22 meetings that take place, although termed
23 "negotiating sessions," frankly, do not always
24 feel like negotiating sessions.

1 The -- in -- in things I've written, I
2 propose that we move to a formal rate setting
3 process in Massachusetts, a la, Maryland or
4 West Virginia. I understand there are
5 objections to that. Short of a formal rate
6 setting process, there is a role that could be
7 set -- could be taken by the Commonwealth,
8 perhaps through this very division, in
9 producing benchmarks of appropriate
10 reimbursement rates for different kinds of
11 services, appropriate adders to -- by the way,
12 this could take place under a global kind of
13 approach or a fee-for-service approach --
14 appropriate adders for education programs,
15 teaching programs offered by academic centers,
16 appropriate adders for different population
17 characteristics, different income levels of
18 different part of the state and so on short
19 of -- of -- of offering a formal rate setting
20 process.

21 But to be an honest broker providing those
22 kind of metrics or -- or ranges so that when
23 the negotiations actually take place between
24 providers and insurers, there's a standard out

1 there that everybody could look at and say,
2 if -- if the provider wanted more money or the
3 insurer wanted to pay less money, at least
4 somebody in the room could say, "But the
5 division has come up with these benchmarks.
6 Why should the rates we're talking about here
7 in this particular negotiation be different
8 from the benchmarks?" At least, then, you'll
9 have a discussion, an explicit discussion about
10 what might be countervailing factors or other
11 factors that could come into play, because
12 there very well could be. There is a
13 complexity of this that rate setting doesn't
14 always get at.

15 So I would offer that as a cascading set of
16 things that the state could do. Review the
17 insurance company administrative expense, act
18 as a purchaser, as a more knowledgeable
19 purchaser and influence the use of primary
20 care, transparency, expanded transparency, have
21 a government presence in the negotiating
22 sessions, have benchmarks established by the
23 division and then moving onto formal rate
24 setting.

1 And then the final thing I would say is I
2 think the state needs to take a more direct
3 role as it -- perhaps not exactly in the way it
4 used to before but in determination of need in
5 terms of what services need to be provided by
6 which hospitals.

7 I mentioned this yesterday in my testimony.
8 Ellen Zane's hospital, my hospital, Boston
9 Medical Center, Massachusetts General Hospital,
10 Brigham & Women's Hospital, Lahey Clinic,
11 U. Mass. Memorial, all provide solid organ
12 transplants to the people of Massachusetts.
13 There are not enough livers, kidneys and
14 pancreas to justify all those programs.

15 Why do we do it? Well, we do it because
16 our faculty, who are very expert and the like,
17 feel it is an important part of their mission,
18 their societal mission and their professional
19 mission. Someone has to tell us no. It is not
20 appropriate to do that.

21 The Brigham, for example, as I understand
22 it, has begun to offer face transplant surgery.
23 One of my doctors said, "We should do that,
24 too," and I said, "I think society has enough

1 facial face transplant services at the Brigham,
2 and we don't need to create another one across
3 the street." But that's the way these kinds of
4 discussions happen and for those of us who are
5 CEOs or department chiefs in these academic
6 medical centers, we sometimes need to be told
7 no, you can't do that, for very expensive
8 procedures. We need to be told -- there's a
9 case involving Lawrence General and Holy
10 Family, who, for quite some time, have shared
11 cardiac catheterization facilities. Recently,
12 the Caritas Christi system decided to go off on
13 its own and break apart that alliance. There's
14 no economic or societal reason to do that.
15 There may be a commercial reason for Caritas
16 Christi to do that, but is society overall
17 benefited by that? No.

18 We had a -- a linear accelerator in
19 Waltham, which I offered to share with
20 Newton-Wellesley Hospital rather than have them
21 build a new facility because ours was under
22 utilized. They chose not to do that because
23 they wanted to, for commercial reasons, have
24 their own facility. Examples like that happen

1 over and over and over again, and I think the
2 state needs to take a more active role in those
3 determinations.

4 Q. I want to thank you for your testimony here
5 today.

6 A. Thank you.

7 Q. That concludes my questions.

8 A. Thank you for having me.

9 Q. To the extent that there's anything
10 supplementally you want to submit to the
11 record, I understand from Commissioner Morales
12 and his -- Athena Carrington that the record
13 will remain open through this coming Friday and
14 both you and others, if you wish to supplement
15 once you review your questions, please do that
16 by that timeframe.

17 A. Thank you for giving your time today. I
18 appreciate it.

19 MR. O'BRIEN: If I could call Ms. Ann
20 Ford.

21 Does our court reporter need a couple
22 minutes?

23 (Off the record.)

24 MR. O'BRIEN: If we can go on record, and

1 I'll start that record with thanks to all
2 the court reporters who have done the
3 only work through this process. It's not
4 easy to take these examinations, and this
5 type of colloquy can be very, very
6 difficult, so we appreciate the hard work
7 that's gone into the hearing process.

8 For the examination -- the next
9 examination of Ellen Zane, I would note
10 for the record that she was sworn in
11 earlier.

12 BY MR. O'BRIEN:

13 Q. Do you understand that you are still under
14 oath?

15 A. I do.

16 Q. And the same kind of format that I followed
17 with -- with Paul Levy as far as trying to
18 analyze some of the -- some of the findings and
19 some of the content of what has been presented
20 through these hearings.

21 But I would start with the same place I did
22 with Paul, which is please state your name and
23 background and to the extent that earlier you
24 indicated what capacity you were hear

1 testifying on behalf of, please do so again.

2 A. My name is Ellen Zane, and I'm president and
3 CEO of -- of Tufts Medical Center and the
4 Floating Hospital for Children. And as I
5 mentioned earlier, I am not here in the
6 capacity as the chair of the Massachusetts
7 Hospital Association, which I am serving in
8 that capacity right now.

9 Prior to my appointment at Tufts in -- I
10 came to Tufts in 2004. Prior to that, I was
11 network president for Partners Healthcare
12 System, founded by the Mass. General and
13 Brigham & Women's Hospital, for ten years. And
14 I believe that that perspective gives me a
15 unique perspective for these hearings, given
16 that I was involved with Partners from its
17 inception in 1994 until 2004.

18 Prior to that, I was CEO of Quincy
19 Hospital, which at the time was a
20 municipally-owned public hospital managed by
21 Hospital Corporation of America and Quorum
22 Health Resources. So I worked for the
23 for-profit enterprise out of Nashville Hospital
24 Corporation of America when I managed Quincy

1 Hospital.

2 Q. That's an extensive and, obviously, impressive
3 background of -- of experience in -- in medical
4 care, and I think that some of the comments
5 that -- during the panel that you participated
6 in talked about the significant need to --
7 of -- of addressing the identified problems in
8 the market, both through consumer approaches
9 but also through provider approaches and in
10 changing culture about where we're at.

11 And so now that you're being examined here,
12 I'd ask whether you have some additional
13 comments that flowed from your presentation and
14 question and answer earlier with regard to
15 those cultural shifts?

16 A. It was interesting to me when you asked about
17 the cultural shifts that providers should
18 engage in, because in my view I continue to
19 believe that all roads lead to this gap, this
20 pricing disparity that exists in the market.

21 And let me give you an example. In the
22 Attorney General's report, it was noted that
23 out of approximately the ten best reimbursed
24 hospitals in the Commonwealth -- actually, I

1 believe in the neighborhood of eight of them
2 are community hospitals, not academic
3 hospitals. And one of those community
4 hospitals recently approached several of the
5 obstetricians on my medical staff, offered them
6 significant salary increases well above market
7 where we believed participating in that bidding
8 contest would have really warped the salary
9 compensation of obstetricians in our region,
10 and we chose not to participate in that and
11 lost our most productive obstetricians to
12 this very well reimbursed community hospital.
13 And it is a very good example of what happens
14 in the world of the haves and the have not's,
15 because the haves used their additional
16 reimbursement in order to compete against the
17 have not's, if you will, those of us that are
18 reimbursed below the median. So when we talk
19 about the culture of how we interact with one
20 another, that culture is unlikely to change
21 unless we understand how to rectify and close
22 the disparities gap that's associated with the
23 market distortions that exist today.

24 Q. And one of the findings of the Attorney

1 General's report, and I'll -- I'm going to jump
2 around to some extent, was on the higher
3 compensated hospitals gaining market share, and
4 Mr. Levy testified earlier that physician
5 organizations and alignment of specialists are
6 helping to drive that in part. Is that
7 consistent with your experience and your
8 example and otherwise?

9 A. It's consistent with my experience in general.
10 What has happened as a result of significant
11 differentials that are provided to certain
12 providers in healthcare systems, that it begets
13 the opportunity for them to enhance the number
14 of physicians that work under their umbrella.
15 That begets more market share and that begets
16 more costs to the overall system. So we can
17 see how the funneling of dollars
18 disproportionately in one direction or another,
19 ultimately, further works to warp the overall
20 system balance.

21 Q. I think that the -- the examination this week,
22 the hearings have been generally very
23 supportive of both payment reform and the
24 importance of integration of care. How -- how

1 is integration of care, appropriate integration
2 of care, different than something that might
3 have a warping effect upon care?

4 A. Let me just step back for a moment and say that
5 I agree with what Paul Levy said relative to
6 the fact that global payments in and of
7 themselves, more integration, and that is
8 viewed in -- in the lingo we've talked about in
9 these hearings, in and of themselves will not
10 necessarily stop the warping behavior.

11 If I am a fee-for-service provider and I am
12 a low-cost or a low-reimbursed and low-cost
13 provider in a fee-for-service world, then I am
14 going to have a lower trend in overall
15 healthcare costs than a highly reimbursed
16 high-cost global provider. In your report, the
17 Attorney General's report clearly showed that
18 that's the case.

19 So global payments in and of themselves are
20 a mechanism to potentially better align
21 providers all sitting at the table at the same
22 time thinking about how to better provide more
23 efficient and safer care. But unless we deal
24 with the distortions in the market in and of

1 themselves, those -- that type of reimbursement
2 will do nothing to fix the underlying problems.

3 So it goes back to the fact that I keep
4 saying over and over that all roads lead to
5 understanding we have a system out of balance
6 and that we have to do something in order to
7 close that gap or we're going to continue to
8 have the same problems we've been talking about
9 for the last three days.

10 Q. If I could ask you to follow up that question
11 and answer by addressing the -- the -- by
12 separating from payment structure, the issue of
13 appropriate integration of care. QCC has a --
14 issued a report that was produced with the
15 Department of Public Health, "Work on
16 Transitions in Care and the -- the
17 Opportunities to Improve Health Through
18 Integration." How is -- is -- is that
19 integration and that kind of the alignment
20 of -- of providers in a continuum different
21 than payment reform?

22 A. Integration of providers where providers are
23 under a -- a common tent, where they're working
24 together at the same table, where they have

1 aligned incentives to do the right thing is a
2 very good thing, and we have number of examples
3 of how that is existing in the market today.
4 So all of us would agree that having a
5 situation where it isn't about the doctors and
6 the hospitals but it's about how a system of
7 care talks about a population of patients and
8 how to better improve the health status of that
9 population is integration and is a better way
10 of providing care.

11 As we said in this morning's panel, in
12 order to develop the glue that keeps all of
13 those providers together and helps them to
14 communicate and operate as either a virtual or
15 an absolute single enterprise is costly, and
16 there are new costs associated with purchasing
17 and putting in place that glue. But having
18 said that, I think all of us believe that at
19 the end of the day, rather than having
20 disparate providers that are not glued together
21 and that have no alignment of incentives and
22 therefore are fragmenting care, that it's
23 better for us to be in a system of care than
24 not. Is that helpful?

1 Q. Yes. Yes, it's very helpful. As far as the --
2 I think that during the panel there were
3 discussions of both some of the providers and
4 what they've accomplished as far as integration
5 and some of the platform necessary to manage
6 both performance risk and some form of
7 insurance risk, some form of risk contract, and
8 the moderator actually mentioned about other
9 states that actually had a kind of more
10 centralized process around that platform for
11 managing risk. Do you have a sense as to what
12 the Commonwealth should do to either incent
13 those who don't have the medical information
14 structure or to -- to look at more system wide
15 approaches to that -- that infrastructure
16 development to -- to foster global payment
17 structures?

18 A. First of all, let me say that I do not believe
19 that there's a difference between insurance
20 risk and performance risk. It's all risk. And
21 when insurance companies choose to capitate
22 providers, and that's typically, at the end of
23 the day, what it is, they are moving the risk
24 off of their balance sheets onto the balance

1 sheets of the providers. And the insurance
2 companies at that moment absolutely know what
3 their costs are going to be going forward. It
4 is the provider at that point that does not.
5 So as I often say publicly, it is hocus pocus,
6 in my view, to say that there is such a thing
7 as the separation of insurance risk and
8 performance risk, because I fundamentally don't
9 understand how that would operational-wise
10 itself.

11 So in terms of whether or not the state
12 should be helpful in getting everyone more
13 ready to become more aligned, I think in our
14 state, as we look across the Commonwealth, one
15 size doesn't fit all. And there are parts of
16 the Commonwealth where folks are absolutely
17 ready for this and desirous of it, and then
18 there are other parts where the infrastructure
19 isn't even close. So I think we do have to
20 look at providers who are ready and are able
21 and are willing to try, and I think quite
22 honestly, the development of relationships in
23 Blue Cross's AQC contract is, in part, an
24 example of providers who were willing to begin

1 to go down that road. That's a non-traditional
2 fee-for-service oriented road. But as Paul
3 Levy said, the conditions of under which we do
4 that have to be correct, because if they are
5 not, it can have a devastating impact on the
6 provider community involved.

7 Q. Now have -- has your medical center entered an
8 AQC with Blue Cross?

9 A. Yes, we have, Tufts Medical Center has.

10 Q. And were there additional costs? And, again,
11 I'm not looking for levels of detail that you
12 wouldn't have with you, and this is not a
13 30(b)(6) looking to bind your medical center.
14 This is just your information as an individual
15 witness. Do you have some sense of cost or
16 community structure changes that resulted from
17 the acceptance of the AQC?

18 A. Yes, there are absolutely new costs associated.
19 And I can't tell you off the top of my head
20 exactly what they are, but it is as we
21 discussed earlier. In order to succeed in an
22 AQC or a capitated contract, one has to have
23 excellence in data, and I want to go back to
24 that in a moment, and one has to have the

1 infrastructure that makes it so that the
2 physicians and all the providers in the system
3 have timely information so that we can make
4 course corrections quickly if our medical spend
5 is untoward. And the issue, historically,
6 between health plans and providers has been the
7 Holy Grail of data. It sounds like a pretty
8 ho-hum concept, but the fact is it is the most
9 valuable asset of a health plan, and the health
10 plans know considerably more about how
11 providers function than providers know about
12 themselves.

13 So it is an incredibly dangerous thing for
14 a provider system to take on risk like in an
15 AQC contract if they are flying blind and they
16 don't have very sophisticated real-time data
17 about their performance. And any provider
18 system that would acquiesce and take on that
19 risk without that data is truly risking the
20 long-term, even the short-term viability, of
21 their system.

22 Q. Can you give us some examples of the kinds of
23 data held by a health plan that allow or
24 facilitate the management of risk by a

1 provider?

2 A. It's largely claims data. That's -- that's
3 basically what they have access to that
4 providers don't.

5 So as a primary care physician submits a
6 claim to a health plan and then the primary
7 care physician sends the patient to a
8 specialist in Timbuktu, and the specialist
9 submits a claim into the health plan, and then
10 the patient gets, perhaps, hospitalized, and
11 then the patient goes to a long-term care
12 facility or rehabilitation facility. As you
13 can see, the claims information gets bigger and
14 bigger and potentially very far a field of the
15 original primary care provider who started the
16 cascade to begin with.

17 The health plans have all that information,
18 whether it's associated with the actual
19 provision of the care, pharmaceutical
20 utilization and all of the other ancillary
21 utilization. Very important in order for us to
22 understand whether the patients are in
23 compliance with the healthcare treatment plan,
24 and it's extremely important information for us

1 to know whether or not the patients are seeking
2 care as prescribed by the doctor.

3 Q. Is it -- is it -- is part of the result of the
4 differences in information for your system a
5 result of the fact that hospital-based care and
6 certain types of care within -- within your
7 structure and that other types of services that
8 might take place for the patients who are
9 served by your -- by your facility are served
10 by other institutions which aren't part of the
11 same entity?

12 A. The -- the real perverse part in all of that is
13 the fact that in -- in Massachusetts, as we
14 discussed in our panel earlier, patients have
15 an appetite for a great deal of choice. And in
16 their view, they have an insurance card and
17 that -- that card tells them that they can have
18 their gallbladder done at Cape Cod Hospital, at
19 Brockton Hospital, at Tufts Medical Center or
20 at the Mass. General, and they basically feel
21 they can do what they want to do based on the
22 fact that they've got an insurance card.

23 Couple that with the fact that the PPO
24 market is growing and the HMO market is not.

1 So more and more patients have utter access --
2 unfettered access pretty much when they want
3 it. So it is exceedingly difficult to
4 integrate the care when patients believe they
5 have a contract in their insurance card that
6 tells them they can go in and out of systems of
7 care whenever they feel like it.

8 And where I took exception to what our
9 moderator said earlier today about the role of
10 the patient is the fact that it's -- it puts
11 the physicians in a position where the
12 physicians have to play cop with the patients
13 in order to say to the patients you should go
14 left instead of right, and the patient looks up
15 and says, "But my insurance contract promises
16 me that I can go left instead of right." And I
17 don't believe that physicians are cops. I
18 believe physicians are advocates for their
19 patients, and that's what they should be for
20 their patients.

21 And I implore the business community and
22 the consumers of the Commonwealth to work with
23 us so that we're not set up to fail by giving
24 consumers unfettered access and then turning

1 around and saying to providers, "But you're
2 providing too much care and it costs too much,"
3 when the consumers think they have the absolute
4 right to that.

5 So I think it's important to understand
6 that this is a multifaceted problem. It has to
7 do with what the business community asks the
8 health plans to design, what the health plans
9 and the business community tell the consumers
10 to expect, as well as the efficiency and
11 efficacy of what providers provide.

12 Q. I expect you haven't reviewed all of the
13 pre-trial testimony that's been filed in this
14 matter.

15 A. A fair amount of it.

16 Q. A fair amount of it. I think -- because I
17 think -- I'm going to -- I'm going to quote
18 something and, obviously, you're not here to
19 testify as to whether I'm quoting it correctly,
20 but it was Atrius, in his pre-file testimony,
21 he said the following: We believe that PPOs
22 drive up costs and promote fragmentation of
23 care. PPOs are designed to work in a
24 fee-for-service environment that most would

1 agree promotes unnecessary utilization of
2 services. PPOs are not designed to work with
3 global payments. To reduce costs trends
4 without sacrificing quality and consumer
5 access, consideration should be given to ways
6 to decrease and restrict the prevalence of PPOs
7 in the state.

8 Would you agree with that statement as I've
9 read it?

10 A. I would largely agree with that statement as
11 you've read it.

12 Perhaps a modification to a PPO product
13 might be a requirement that there be a
14 quarterback, that there be a primary care
15 physician or primary care clinician that is
16 mandating it as part of the PPO product.
17 Today, by definition, it doesn't require that.

18 And I don't use deliberately, the word
19 "gatekeeper." That's the old-fashioned
20 terminology, because it's not about keeping
21 people out of -- on the other side of the gate.
22 It's about the advocate that navigates the
23 care, the quarterback that orchestrates the
24 care and that's only good. So it would seem to

1 me that that statement is largely correct, but
2 there could be some experimentation associated
3 with the fact that if there is a primary care
4 physician assigned, it would help a lot.

5 Q. And if I -- if I could kind of follow up on
6 that assignment of a quarterback, to use your
7 term, would he or she be restricted if they
8 don't have information on the downstream costs
9 associated with the provision of care that --
10 that their helping to direct?

11 A. I think -- could you repeat that.

12 Q. Sure. Sure. Let me -- let me rephrase it.

13 I think that earlier you said that
14 excellent information on claims experiencing
15 some of the downstream cost once a -- if
16 recommendation is made by a physician. Is --
17 in a PPO structure where you had a quarterback,
18 would that quarterback need to have the
19 information of the downstream costs in order to
20 effectively manage care?

21 A. I believe the quarterback would need that
22 information, especially if there is any kind of
23 risk involved. They absolutely, positively
24 would need that information.

1 But in your earlier question you asked
2 about integration versus not being integrated
3 and if we're really talking about integrated
4 care, we need the data.

5 Q. And with regard to your -- your risk associated
6 with the AQC, are you at risk for the
7 downstream costs, if you could kind of explain
8 what is your risk and what isn't your risk
9 under the contract you have?

10 A. Largely, from a -- from a 10,000 foot -- yes,
11 we are. We -- we don't have 100 percent of the
12 risk but we have a significant amount of risk
13 such that people pay absolute attention, and if
14 at the end of the day there are huge deviations
15 from the quality metrics that are liberally
16 built into -- into that contract, then there
17 can be significant downside -- downside
18 outcomes for the medical center and its
19 physicians.

20 Q. And with regard to those -- to that product, is
21 that -- how much of your -- forgive my -- the
22 nomenclature, book of business with Blue Cross
23 is covered by the AQC?

24 A. About half, because the way -- as we looked at

1 our Blue Cross business, about 50 percent,
2 perhaps a little more, was PPO, and about less
3 than 50 percent was HMO, and the AQC covers the
4 HMO population, not the PPO.

5 Q. Now, do you have in your PPO structure, primary
6 care physicians within your -- within in your
7 entity?

8 A. Within our what structure?

9 Q. To the extent that within the HMO structure,
10 are the -- are primary care providers, whether,
11 again, are nurse practitioners or physicians,
12 are they part of your team?

13 A. Yes. I'm sorry, yes. Between the physicians
14 that are part of the faculty practice plan, the
15 academic physicians at the medical center and
16 the community network called "NECWA" that we
17 have, the primary care physicians in both of
18 those buckets, if you will, are part of the AQC
19 for the HMO patients.

20 Q. And are -- do some of those primary care
21 providers also provide services on -- to PPO
22 individuals?

23 A. Yes, almost all of them do.

24 Q. And do you receive similar information to help

1 those "quarterbacks," to use your term, manage
2 care at the same level for the PPO products as
3 you receive for the HMO product?

4 A. I don't believe so, because they can't. The
5 problem is, is consumers have no quarterbacks
6 in a PPO. It's very fragmented. That -- the
7 term from Atrius is correct. It's all over the
8 place with no systemic way of -- of looking at
9 it or controlling it. So there's no data --
10 there's no place to funnel it to and funnel it
11 through.

12 Q. If -- if -- if the -- if the primary care
13 physicians had access, your primary care
14 providers on the PPO side, would that be
15 beneficial to their ability to help as primary
16 care providers, direct and help guide
17 consumers, their patients in the process?

18 A. That's an important question. Because I
19 believe that if physicians had the data, they
20 absolutely would not discriminate in how they
21 treat patients. If there's anything that most
22 physicians dislike, it's two levels of care.
23 Physicians pride themselves and view themselves
24 as advocates for patients, and they want to

1 provide great care irrespective of the
2 insurance card.

3 So if they had the data, it would seem to
4 me that the excellence in the systems they
5 developed would migrate to all of the patients
6 that they provide for, if it's best in class
7 care.

8 Q. To the extent that it -- that through this
9 examination we found out that as far as the
10 networks of health maintenance organizations,
11 they're not limited. They have -- you have --
12 the network is complete, as complete as the PPO
13 networks.

14 A. Yes.

15 Q. What is the rational reason for only providing
16 that kind of quarterback level of information
17 on the HMO side and not on the PPO side, if you
18 know of a reason?

19 A. I don't know of the -- I don't know of the
20 reason, and it is unusual from an intellectual
21 point of view that our HMO networks here are as
22 complete as you say as the PPO networks. In
23 some cases, the premiums are actually higher
24 for the HMOs than they are for the PPOs. It

1 defies logic in a lot of respects, and I think
2 it is virtually another example of how
3 distorted this overall market is in its
4 behavior.

5 So we need to think about what kind of
6 products we should be providing, and how we
7 should be providing them, and how we should be
8 pricing them in order to make much more
9 rational sense for the delivery of care in the
10 market.

11 Q. To stay on the -- on the HMO side of the
12 product divide, prior to the AQC and post AQC,
13 is there a difference in the level of quality
14 of the data you're receiving from Blue Cross?

15 A. Yes. The moment we signed the AQC contract, we
16 got a significantly enhanced level of
17 cooperation from the folks at Blue Cross
18 relative to their willingness to provide data.

19 Now, I can't tell you chapter and verse,
20 but the feedback I get from our team is that it
21 hasn't been as forthcoming and as fast as had
22 been suggested, but it has been of different --
23 a different level of cooperation over what was
24 the case before.

1 And the theory behind it was that Blue
2 Cross has more or less bet the farm on the AQC
3 effort and that they want us as providers to
4 succeed. And, quite honestly, we want to
5 succeed in that product, and we want to show
6 great outcomes, and we value the fact that
7 we're a value provider. So all of us are
8 aligned in that, and it makes sense for them to
9 want to work with us, to give us the data so
10 that we can all succeed. That's the rational
11 part of it.

12 The irrational part of it is that sometimes
13 in working with health plans, what seems to
14 make sense for the market just doesn't seem to
15 happen, so.

16 Q. So to the extent that there was another
17 academic medical center that hasn't yet entered
18 an AQC, your sense would be that -- that
19 they -- that -- and, again, I'm not -- you
20 know, this -- to the extent that this might be
21 calling for speculation, feel free not to
22 answer. It would be your expectation on that
23 that they would not be receiving for their
24 primary care providers, the same level of

1 information to be patient advocates that
2 your primary care providers are getting on one
3 half of the product line, which is the HMO
4 product line?

5 A. Based on my own experience, I would say that
6 that would be a true statement. I can't speak
7 for others, but based on my own experience that
8 would be the situation.

9 Q. With regard to the -- the report, and so rather
10 than walk me through, because I think there's
11 been some -- a lot of interesting comments, I'm
12 going to just read through the seven kind of
13 major findings of the Attorney General's
14 office. Then I'm going to go through some of
15 the major findings of the division. To the
16 extent that I'm leaving out some of the
17 division's, you know, incredible work, I hope
18 they will forgive me.

19 And I'll ask you two things. One, is what
20 did Paul say that was wrong and if there was
21 any thing --

22 A. Nothing.

23 Q. Nothing.

24 And then -- and then, what -- what, of

1 those findings you want to comment on?

2 A. Okay.

3 Q. So the findings, as -- as I would read through
4 them, and I -- I might turn them into six, is
5 that prices paid to insurers from -- by health
6 insurers to hospitals and physicians aren't
7 correlated to quality of care, sickness or
8 acuity of the population, the percentage of
9 Medicare, Medicaid or whether it's -- the
10 facility is academic teaching or not. So
11 that's one set.

12 Second, is that price variations are not
13 adequately explained by differences in hospital
14 costs. So that's two.

15 Three, is that they are correlated to
16 leverage within the marketplace, three.

17 Four, that total medical expenses on a per
18 member, per month basis isn't correlated to
19 whether provider is fee for service or risk
20 sharing in some way. So that's four.

21 Five, is that price increases more than
22 utilization are a driver of current medical
23 trend over the last few years.

24 And six, if I'm counting right, higher

1 priced hospitals are gaining market share, and
2 seven, the commercial healthcare marketplace
3 has been distorted by contracting purchased.

4 Of those seven, are there any -- I'll ask
5 you first, are there any you disagree with
6 based on your experience?

7 A. No.

8 Q. Okay.

9 A. I really like that chart over there, the one in
10 the middle. Because as far as I'm concerned,
11 it says it all.

12 Q. And that's the chart that shows that your CMI
13 or the CMI for your organization --

14 A. Is the highest.

15 Q. -- your relative -- your relative payment rate,
16 for at least that particular provider, and the
17 differences in market leverage proxies that
18 we -- we used on that is -- is less.

19 A. It -- that chart really summarizes the seven
20 points you made, and says it really
21 beautifully.

22 Q. I'll let who's ever behind bubble charts know
23 that you're a fan of it.

24 As far as contracting practices, do you

1 have contracting practices that -- that
2 restrict the ability of health insurers to
3 innovate, whether it's participation
4 requirements or?

5 A. Yes. There are contracting practices that are
6 operative in this market that are restricting
7 plans from the ability to innovate. Product
8 participation agreements that don't allow for
9 it, and they exist, are problematic, because it
10 means that the health plans really can't go out
11 there and do things like true limited networks.
12 So product participation agreements are a
13 problem.

14 There are -- there's a contracting practice
15 about caps on health plans where health plans
16 say they do not want providers to grow their
17 networks of physicians and, therefore, they cap
18 them in terms of how many doctors can come into
19 the system. And in my own negotiations, I've
20 scratched my head about that and I've said,
21 "Let me understand this. If we, as a high
22 quality, high case mix, low cost --
23 low-reimbursed provider are able to grow our
24 network, then that means you as an insurer, a

1 health plan, stand by what you represent to the
2 business community by looking out for their
3 interests in providing care more efficiently
4 and more cost effectively. Why would you cap a
5 provider who can help you do that?" And I have
6 yet to get a sensible answer to that.

7 Now, in our own situation, we've been able
8 to negotiate that to a -- to the ground where
9 we needed to, but it is a contracting practice
10 that is pervasive in this market. That is
11 wrong, where there are games that are played
12 with -- with some of the systems that are
13 capped so that as many high cost and
14 high-reimbursed providers as possible get in
15 under those caps, and who benefits from that?
16 Certainly not the business community, certainly
17 not consumers. So that's another contracting
18 practice that's a problem, and as you know,
19 there's most favored nation clauses that are
20 out there, too. So there are a number of
21 contracting practices out there that absolutely
22 inhibit innovation.

23 Q. To put a bit of a point on -- on that, there
24 are, in the commercial marketplace, one -- one

1 health plan has more than 50 percent of the
2 market and there are two other commercial
3 health plans that have, also, significant
4 market share, which is not -- as compared to
5 the largest net, and those being Blue Cross,
6 Tufts Health Plan and Harvard Pilgrim Health
7 Care. Do you -- are these types of restrictive
8 practices in place with -- with each of them?

9 A. I believe so.

10 Q. Going back to one of the other findings of the
11 Attorney General's report with regard to total
12 medical expenditures, do -- do you get, as part
13 of the AQC information on total medical
14 expenditures, is that what's being tracked in
15 the context of -- of -- of the AQC contract?

16 A. Pretty much, yes. I couldn't give you chapter
17 and verse on all the details, but the idea is
18 to understand underneath the capitation
19 arrangement that we are in, what our costs are
20 and what the service provision is so that we
21 can track against the expectation.

22 Q. And did you receive total medical expenditure
23 and/or comparative total medical expenditure
24 information in the past from Blue Cross?

1 A. No, not nearly as comprehensively, and what
2 cause -- causes negotiations to become
3 protracted is when one has difficulty getting
4 historical comprehensive information so that
5 you know what your base is when you negotiate
6 to the future. If one doesn't know one's base
7 activity, it's impossible to know what one
8 should expect in the future and leads to the
9 flying blind syndrome.

10 Q. Now I'm going to read through some of the --
11 what I -- what I've pulled from the division's
12 reports as some of the key findings, and I just
13 wanted to -- I'll lay them all out and ask you
14 to comment on those that you either disagree
15 with or -- or have no comments on.

16 First, the division's various reports noted
17 that small group premiums grew faster than
18 midsize and large but not by significant
19 amounts. Small group premiums grew 5.8 percent
20 on average. Large group at 5.4, and midsize at
21 4.8. So that's one finding.

22 Two, is that medical trend for 2006, 2008,
23 was in total 15.5 percent.

24 Three, that outpatient services, including

1 medical procedures, imaging and laboratory,
2 which can be provided without an overnight
3 stay, kind of grew as a percentage through
4 hospital-based facilities, outpatient services.

5 And then two more that I'd -- I'd mention
6 is that the way healthcare providers are paid
7 rewards, those that provide a high number of
8 individual services, as opposed to best
9 coordinated. And the last one I'd just
10 reference is that healthcare system is
11 dominated by a high number of specialty
12 doctors and -- our healthcare system by -- by a
13 number -- high number of specialty doctors and
14 academic and medical centers, and so I wanted
15 to lay them all out to see whether a particular
16 one of those that you disagree with based upon
17 your experience?

18 A. So, could I pose upon you to go through them
19 one at a time?

20 Q. Sure. I'll go through them one at a time.
21 That -- that's fair.

22 A. Thank you.

23 Q. Starting with the -- the average growth of
24 premiums, small group being at 5.8, slightly

1 more than large group and midsize group, is
2 that -- do you have information which would
3 show that -- that would be consistent or
4 inconsistent?

5 A. That would be -- because I would agree with
6 what Paul Levy said, because I am not in the
7 insurance side of the business, I can't
8 basically say that. I know what I read in the
9 paper, but -- but, personally, other than what
10 I see happen for our own employees at Tufts
11 Medical Center, I can't necessarily say that
12 that's --

13 Q. And from your perspective, much like Beth
14 Israel Deaconess's perspective, rates with
15 health plans aren't set differently for small
16 groups versus large?

17 A. Right. His -- his answer to that was
18 absolutely correct. A gallbladder is a
19 gallbladder, irrespective if whether it comes
20 from the local florist shop or from Gillette.
21 So the fact is that we're -- we negotiate
22 rates, and I must say, parenthetically, that
23 when I've heard the Mass. Association of Health
24 Plans talk about the reason that small business

1 premiums are as they are is because of provider
2 cost, I -- I -- I really find that comment
3 quite galling. Because the fact is we all know
4 if we look at the real facts around that,
5 that's -- that those small business premiums
6 are designed around rate bands that have
7 absolutely nothing to do with what any of us
8 are paid for our gallbladders and that the
9 gallbladders are the same irrespective of
10 whether the patient comes from the local
11 florist or -- or Gillette.

12 So the small business premiums and the
13 hubbub that we're experiencing today about what
14 to do for small business, I feel is
15 misdirected, when we're not really looking at
16 how small business premiums get built. And so
17 I actually feel the -- the emotion and the
18 visceral reaction about what's happening with
19 small business is not consonant with the reality
20 of how those premiums are made.

21 Q. The next was that they looked at growth trend
22 from 2006 to 2008, from medical growth trend at
23 15.5 percent. Actually, termed it as "private
24 spending per insured individual for

1 healthcare," to be more precise, at
2 15.5 percent. Is that consistent with what you
3 see happening as far as medical trend based
4 upon your experience?

5 A. Absolutely not. Because some of us are pooled
6 in the have not category. I believe we have to
7 be better managers, and we have had to work
8 very hard in order to make sure that our
9 medical -- that our cost trends are as flat as
10 possible, and we have worked doubly hard. So
11 whatever those premium trends are, they
12 certainly aren't interpreting to the
13 reimbursement that -- at least, we see, at
14 Tufts Medical Center.

15 Q. The next that I've referenced for you is that
16 outpatient services, including medical
17 procedures, imaging and laboratory, which can
18 be provided without an overnight stay in a
19 hospital, their -- the growth and spending for
20 care in outpatient hospitals was due in large
21 part to growth in the prices and volume of
22 imaging services, medical procedures and cancer
23 therapies provided. Do you have a sense as to
24 whether those --

1 A. So, I have an issue with the comments that have
2 been made everywhere relative to utilization on
3 the outpatient side, because it's my
4 understanding that more research needs to be
5 done on that relative to how we count
6 outpatient procedures. And, although, I,
7 again, can't cite chapter and verse, it's my
8 understanding that over the last several years
9 there have been changes in how units are -- are
10 counted. So I'm not sure that those
11 utilization increases, even though it's the
12 smaller piece with the larger piece still being
13 price, I'm not sure the utilization piece is
14 correct.

15 Q. Have you seen in the marketplace, a shift
16 towards outpatient facilities being -- or that
17 type of care being aligned with hospitals as
18 opposed to freestanding?

19 A. Yes. Yes. There are -- yes, in large part.
20 We shouldn't forget, however, that a fair
21 amount of outpatient activity takes place in
22 physician offices that have their own imaging,
23 their own gastroenterology suites and whatever,
24 so it isn't insignificant. But we should be

1 asking ourselves the question irrespective of
2 whether it's a hospital, outpatient setting or
3 a physician or freestanding facility what --
4 what we're mitigating there, because it could
5 be that we are offsetting an inpatient
6 admission by doing that. So outpatient care
7 de facto on the increase is not necessarily a
8 bad thing.

9 Q. The next had to do with the way healthcare
10 providers are paid rewards, high number of
11 individual services and less coordination of
12 care at -- in less expensive settings. Is that
13 consistent with your experience?

14 A. On the -- on one side of it, we all say, "Gee,
15 wouldn't it be better to move away from the
16 piecemeal approach of fee for service. That
17 rewards piecemeal activity." But, on the other
18 side, if one reads your report, it shows that
19 in cases where it wasn't fee for service, it
20 didn't necessarily reduce cost. So it's
21 unclear, I think, the answer for that.

22 Q. And then the last one that I'll reference with
23 regard to the division's reports is that our
24 healthcare system is dominated by a high number

1 of specialty doctors rather than primary care
2 doctors and by academic medical centers, both
3 which tend to provide costlier care.

4 A. Well, I, for one, at Tufts Medical Center say
5 that that does not apply to us when there are
6 eight community hospitals that are a whole lot
7 more expensive than ours. And through
8 serendipity, Tufts Medical Center is a small
9 academic medical center, as compared with our
10 friendly competitors. And it's turning out to
11 be a very good thing, and it's why our case mix
12 index is so high because we don't covet
13 secondary care. We cover it. What we should
14 covet is an academic medical center and that's
15 high-end tertiary and ordinary care. So the
16 fact that we have a lot of specialists is what
17 we should have given our mission.

18 And while we are the community hospital, if
19 you will, for the Chinatown community, for
20 South Boston and -- and for the South End and
21 for Dorchester, having said that, when we look
22 at why our case mix index is as high as it is,
23 it's because we -- our niche is tertiary and
24 ordinary care.

1 Q. With that said, as far as your -- the volume of
2 patients that you see for tertiary, ordinary
3 care, are you disadvantaged by not having a
4 broader provider network of specialists to
5 refer to?

6 A. It -- it is important. As -- as Paul Levy
7 said, "Academic medical centers, by their
8 nature, really do see referrals to their
9 facilities by community primary care physicians
10 and specialists."

11 Our view is that we say to physicians,
12 "You're the doctor. You decide what the most
13 appropriate place is for the patient to receive
14 care. If in your determination, the patient
15 shouldn't receive the care locally because the
16 specialty care is just not there, then we hope
17 that we'll be viewed as a value provider where
18 we are efficient and we are safe and we are
19 high quality and we are lower cost."

20 So we think that we have a responsibility
21 to be a value provider, but it's very important
22 that we do have a network of both primary and
23 specialty care physicians in the community that
24 want to be in our orbit, if you will, because

1 they are comfortable with the local care that
2 they can provide and the tertiary and ordinary
3 care as well.

4 Q. Paul, also, referenced some recommendations
5 in -- with regard to further developing the
6 primary care providers in our -- in our system
7 that really turned on compensation structure
8 and I guess valuing the services that -- that
9 those providers provide. Do you -- do you
10 agree with his perspective on that?

11 A. I do. Primary care physicians complain a lot,
12 understandably, that their coordinating
13 quarterback orchestrating role is really not
14 valued to the degree that it should be and that
15 there's a tremendous amount, that they call the
16 "hassle factor" associated with their work, but
17 there's one other point associated with that
18 that I feel compelled to talk about, and that
19 has to do with the Tufts University School of
20 Medicine. Tufts University School of Medicine
21 is one of America's great medical schools.
22 And by -- by way of contrast, this past
23 graduation, year ago May, Tufts University
24 School of Medicine graduated 170 new physicians

1 with one principle teaching hospital, Tufts
2 Medical Center. By contrast, Harvard graduated
3 150 physicians with five principle teaching
4 hospitals. So one can see that when a provider
5 like Tufts Medical Center is starved from a
6 reimbursement point of view, how not only that
7 affects the survivability of a great medical
8 center but how that can affect a great
9 university and a great medical school. And
10 therefore the pipeline of physicians to this
11 area. By some -- by some quirk that the dean
12 and I don't quite understand, there are more
13 physicians that go to Tufts that happen to
14 choose to remain and stay and practice in
15 Eastern Massachusetts than is the case for most
16 of the other medical schools, and for some
17 reason Tufts graduates more physicians who
18 choose to go into primary care. So if anything
19 ever happens to that medical school or its
20 medical center, then we have forever affected
21 the pipeline of physicians to this region. So
22 when we think about the issues surrounding
23 primary care, it's more than about what they're
24 being reimbursed. It's more than the hassle

1 factor. It's about the pipeline as well.

2 Q. When you say that there's more -- more primary
3 care physicians out of Tufts Medical School,
4 can you put that -- can you put some numbers on
5 that for the most recent period of time, you
6 know, if you -- if you have a sense as to how
7 many primary care physicians are coming out of
8 the Harvard program?

9 A. I can -- I can get that for you. I don't want
10 to quote a number that I don't know, but the
11 dean and I have talked about the fact that in
12 terms of all the primary care specialties,
13 Tufts trumps the other medical schools. In my
14 own experience and my days at Pilgrim's, I can
15 tell you that at Harvard, the number of
16 physicians in primary care are very small.
17 Also, by contrast, Tufts has a family practice
18 program. Harvard does not.

19 Q. This -- we're getting to the close of the
20 examination, and on a Friday afternoon, I'm
21 sure lots of folks are happy to hear me say
22 that, but I -- I also want to not in particular
23 draw your attention to the five -- I think it
24 was five recommendations that Paul had, but I

1 want to hear whether you have a list of
2 recommendations --

3 A. I do.

4 Q. -- and things that we should consider?

5 I don't think that surprises us.

6 A. Yeah.

7 Q. I'd like to hear your recommendations, please.

8 A. One of the things I think we ought to be
9 thinking about is how we standardize our fee
10 schedules so that there's a normalized fee
11 schedule for hospitals and doctors. That isn't
12 to say that everybody gets paid the same thing.

13 What it is to say is the base upon which we
14 make the decisions is based on a standardized
15 definition over all providers, which can then
16 have multipliers put on it for a variety of
17 things, including the acuity of patients,
18 including geography, accessibility, the standby
19 capacity, the societal needs, in other words,
20 that a provider provides.

21 But it would really be nice if there was
22 transparency relative to a well known, well
23 publicized, common definition of what a core
24 set of reimbursement is for both hospitals and

1 doctors. Right now, it is a complete black box
2 with nobody willing to expose that and very
3 little transparency on why. And we should know
4 that even today, health plans have come to me
5 and I'm sure to others and said, "Well, you
6 know, we've got to make sure that all the
7 doctors are on a similar fee schedule." They
8 call it their "vanilla fee schedule." And,
9 yeah, we occasionally need to give you more,
10 but they give it in the term of these
11 supplemental payments, which I always called
12 "wheel barrels of cash" that come in the back
13 door. So I think we need to stop that, and we
14 need -- what we need to do is have a common
15 structured fee schedule that everybody
16 understands that gets built upon based on who
17 you are, where you're located and what your
18 mission is.

19 Q. Before you go on, I assume their might be some
20 more recommendations, I know that the division
21 actually looked at variation by DRG and put the
22 average in and had useful information, and Paul
23 had mentioned benchmarks and what -- and, you
24 know, obviously, my healthcare options starts

1 to get information out that gives kind of DRG
2 specific -- DRG specific information. Is it --
3 is it a benchmarking? Is it taking that --
4 that unexplainable variation, I think is a fair
5 way of putting what the division identified,
6 and starting to squeeze it to say, you know, if
7 you're off, you know, the standard deviation,
8 up or down, you're really getting paid too
9 little or too much. Let's start there.

10 A. Right. Right.

11 Q. And then start to converge, is that the --

12 A. Yes, yes. And I agree with what Paul said
13 about this rush to the top is, I think, a fear
14 but not necessarily a reality. Because just as
15 you've said, there will be a -- there will be a
16 rationale about why fees either go up or need
17 to be red circled or come down. So I do think
18 that standardizing this with a very under the
19 sunlight definition of what these fees are is a
20 good thing.

21 My second recommendation, I believe, is
22 core to what we need to get the distortions out
23 of this market, and it has to do with closing
24 the gap between the haves and the have not's.

1 And when I say this, I always rush to say that
2 I am not Robin Hood and I am not looking to be
3 Robin Hood, and that at least those of us at
4 Tufts Medical Center have no fear of having to
5 earn our way and having to perform well.

6 However, the haves have had the benefit of
7 additional reimbursement for many years, and
8 that reimbursement has compounded year over
9 year over year. Those of us that have not had
10 that luxury are hardly able to reinvest in our
11 facilities or prepare for global reimbursement
12 or a new day, and we are eating our walls.

13 So we really have to take an honest look at
14 what that gap is and help the quality, value
15 providers to live long enough in order to
16 remain viable in this market to fulfill exactly
17 what this -- what this effort is trying to
18 achieve, and that is to have quality, efficient
19 providers at a reasonable cost.

20 And if we don't invest in those providers
21 and close that gap to some degree, then we are
22 putting at risk the fact that their balance
23 sheets are weak because they have not been able
24 to benefit from years of additional

1 reimbursement.

2 Q. And if I -- if I might, and forgive me for
3 jumping in again, but there are some providers
4 who are double A rated?

5 A. Yes.

6 Q. And they are able to drawdown money for capital
7 --

8 A. Uh-huh.

9 Q. -- at far less expensive rates than others.

10 And then there are some who simply can't --
11 can't drawdown the money to rebuild
12 infrastructure.

13 A. Uh-huh.

14 Q. We have capacity issues in some of our vital
15 urban centers, Lawrence is probably an example
16 of it, Brockton, Holy Oak and others.

17 A. Uh-huh.

18 Q. Is there -- is there -- you know, beyond the
19 curve and the disparities, is there -- are
20 there ways in which the Commonwealth can help
21 to facilitate necessary capital improvements in
22 a more collective way than every tub and its
23 own bottom, you know, eat your walls or not?

24 A. It's a very interesting idea. I haven't

1 thought about it, but I do think a way to
2 access capital in a way that's effective and
3 not traditional would be very interesting for
4 those of us that haven't got double A ratings
5 and aren't going to see that because we haven't
6 had the years of additional reimbursement.

7 So it would be an enormous help if the
8 Commonwealth could really look at providers
9 that need that in order to make sure that they
10 are there tomorrow to help provide care for
11 their communities.

12 Q. And part of the, I guess, if I might suggest
13 it, arguments that might be that as a
14 Commonwealth, it's -- you know, these not for
15 profits.

16 A. Uh-huh.

17 Q. It's our capacity. We either pay you now or
18 pay you later.

19 A. Well, there's a tremendous disruption in these
20 communities if these hospitals just continue to
21 get weaker, and that's essentially what's
22 happening now. It's the old rich get richer
23 and the poor get poorer, and it's dysfunctional
24 relative to what it is we're trying to

1 accomplish in care of these communities.

2 Lawrence General is probably a very good
3 example of that, and the Commonwealth could
4 play a role in that. I think it's a great
5 idea.

6 Q. So standardization of fee schedules, closing
7 the gap -- I stopped you after two again.

8 A. Yes. Right. Okay.

9 Q. Go on.

10 A. Limited network, we talked about that earlier
11 today. I -- I do think that the time has come
12 where folk are saying to themselves how much
13 deeper am I going to dig? And if people don't
14 want to pay double-digit increases in their
15 premiums year over year, then we must all begin
16 to make it clear there is a tradeoff. And if
17 we can show that the quality tradeoff is not
18 one of the tradeoffs they'd have to make and if
19 there's support from the government and support
20 from the health plans and support from the
21 business community, we can do this. It's just
22 been a shrugging of the shoulders in the past,
23 with everybody says nobody wants this and
24 everyone wants choice.

1 All things do change. We know nothing
2 stays the same, and I believe that now is the
3 time that the appetite for this could increase
4 and we should try it. That's the next one.

5 The next one has to do with adequate
6 payments from government, and I know that
7 government is between a rock and a hard place
8 right now. But the thing that I have found
9 most interesting in listening to what's going
10 on in these hearings is that while government
11 has brought these hearings forward, government
12 hasn't talked a lot about its role in the
13 dysfunctionality of this market. And the fact
14 is at the time of Chapter 58 in 2006, it was
15 understood and in that legislation that the gap
16 in Medicaid reimbursement had to improve, and
17 at the time, I believe it was \$.84 on the
18 dollar with an aim to move it up to 95.

19 Today, at least at Tufts Medical Center,
20 it's \$.60 on the dollar and dropping, and for
21 those of us like Tufts Medical Center that has
22 20, 21 percent Medicaid, not enough to be a
23 dish hospital and three times more than the
24 others -- the other academic medical centers in

1 Boston other than BMC, the fact is it just
2 doesn't pencil. It's just simply not
3 sustainable.

4 And all of the talk about cross
5 subsidization from the commercial health plans,
6 if you are not one of the leveraging providers,
7 then you can't -- there's just no way that
8 after the close of a negotiation you can go
9 back to the Blue Cross's of the world and say,
10 "By the way, here's another invoice for your
11 fair share of the shortfall in Medicaid."

12 So I -- I have to say I think it's great in
13 Massachusetts, we all do, that almost everybody
14 here is covered in the Commonwealth. But let's
15 really look at who paid for it. Who paid for
16 it?

17 The government takes the credit for the
18 fact that we have high accessibility and the
19 coverage, but the providers are the ones who
20 have taken it on the chin for that. So I think
21 it's inappropriate to say it's all about the
22 commercial health plans. It's all about the
23 providers. Government needs to figure out a
24 way, too, in all of this.

1 And I guess the next one would be another
2 one where I agree with what Paul Levy said as
3 well, relative to insurance administration and
4 would encourage the state to look into that,
5 again, as he said, this focus on providers
6 being \$.90 on the dollar and insurance plans
7 only being \$.10.

8 As a famous Bostonian says, "Nobody was
9 ever cured in a health plan," and the fact is,
10 every day I ask myself more and more, what is
11 the value? Does a health plan need to have a
12 billboard on the Expressway? What value does
13 that bring? And because nobody was ever cured
14 at a health plan, the real value they seem to
15 bring is that they claims process and they
16 sell.

17 But I have to ask myself all the time why
18 are we paying 2 to 3 percent to brokers and why
19 are we paying \$.10 on the dollar when those
20 premiums are getting bigger and bigger and
21 there seems to be economy scale with their own
22 infrastructures getting bigger and bigger?

23 So I think it's inappropriate that we've
24 only said, "Gee, \$.90 on the dollar is what we

1 ought to be looking at because the rest of it
2 is a measly \$.10 cents." When I think there's
3 a lot of opportunity in them there hills to
4 solve the problems of the Commonwealth,
5 including the Medicaid shortfalls, by taking a
6 hard and transparent look at what's in those
7 administrative fees, especially when some of it
8 goes to risk reserves and that risk is being
9 passed to the providers.

10 So the last one is transparency, which
11 we've all talked about. It seems to me that
12 what you have done is a tremendous service to
13 the citizens of the Commonwealth by saying,
14 "Now, that these are facts." It's no longer a
15 discussion about what we think is going on, but
16 what you all and the Department of Healthcare
17 Finance and Policy have done is you have really
18 shown effects, and I think there's nothing like
19 a data-rich environment in order to make good
20 decisions. So I congratulate you on that and
21 say we need to have transparency on all phases
22 of this.

23 Q. That concludes that answer and that concludes
24 my questions, and I thank you for participating

1 in the examination. And, again, I think
2 Commissioner Morales I think, is going to come
3 up and close for us.

4 MR. MORALES: Thank you, Assistant
5 Attorney General Tom O'Brien, thank you,
6 Ellen, thank you, Paul, for your candid
7 responses.

8 We are going to conclude but before
9 we do that, a couple of things. I just
10 jotted some notes. While I'm not going
11 to recap our hearings, I am going to say
12 a couple of things.

13 The first thing is our goal, as we
14 talked about for months, was to be sort
15 of table setters, set a table for a
16 discussion to have you, the stakeholders,
17 discuss our research findings, discuss
18 the real problems that we encountered on
19 our research data, and explain to us,
20 government, but also people, consumers,
21 taxpayers, from your perspective, what
22 some of those issues are and how we solve
23 them. And I think we accomplished that,
24 for the most part, one.

1 No. 2, to have an honest, public
2 discussion that I don't think has
3 happened yet on where we are in
4 healthcare today, how it's impacting us
5 and what we can do about it. I think we
6 accomplished that also. So thank you all
7 for that.

8 Next steps from here, the division,
9 by law, as you know, is required to issue
10 a final report, which we will do in the
11 next three to four weeks, hopefully.
12 That will be done with your input. We
13 will work diligently on that as we've
14 discussed, and then, hopefully, have some
15 legislative action and regulatory actions
16 in that report that we see come to
17 fruition. That's our hope and we will
18 definitely work hard to make sure that
19 happens.

20 The sense of urgency could not be
21 felt more. We've heard it from Senate
22 President Murray, the governor. We've
23 heard it from almost every panelist. The
24 time to act is now. The biggest

1 concerning point for me has been that
2 every major economist that we've invited
3 here has said the same thing, this trend
4 cannot continue and so we know we have to
5 take action.

6 Last but not least, I want to thank
7 every single panelist that was here with
8 us for the three days, the moderators,
9 you in attendance. This could not have
10 happened without some of the tremendous
11 researchers we had along with us, so I
12 want to thank them also publicly.

13 And then I also want to thank the
14 Division of Insurance Commissioner
15 Joe Murphy. John Auerbach was here on
16 day one for the Department of Public
17 Health and Commission of Public Health,
18 and, of course, Tom O'Brien. Attorney
19 General Martha Coakley, your team,
20 unbelievable work and amazing
21 partnership, I want to be very public
22 about that. This has been a tremendous
23 process for us, and last but not least,
24 my team, who has done a tremendous job

1 supporting us, supporting some of the
2 great research, some of the great work,
3 some of the great hearing work you saw
4 today. I could not have done it without
5 my team, so thank you all for that as
6 well.

7 With that, I want to conclude our
8 hearings. Thank you, again, and have a
9 great weekend.

10 (Whereupon, the hearing was
11 concluded at 4:55 p.m.)
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C E R T I F I C A T E

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I, Susan E. DiFraia, Certified

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Shorthand Reporter and Notary Public in and for

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the Commonwealth of Massachusetts, do hereby

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certify that the foregoing transcript, Volume

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Susan E. DiFraia

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Notary Public

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My commission expires 12/10/2011

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